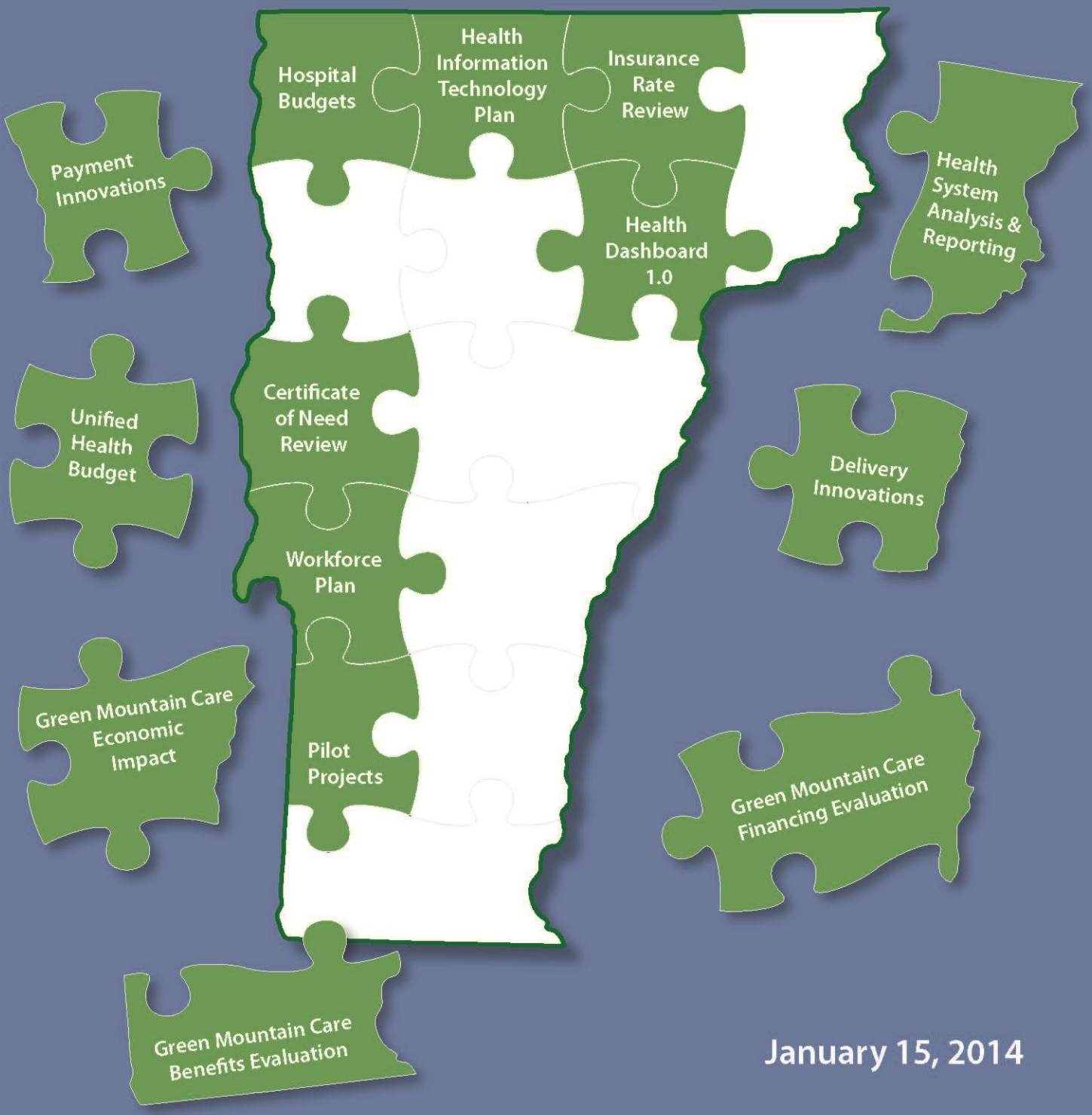
Annual Report of the
Green Mountain Care Board
to the Vermont General Assembly



January 15, 2014

The members of the Green Mountain Care Board wish to express our gratitude to our staff, who bring dedication, creativity, intelligence, shared purpose, and humor to the work of improving Vermont's health care system.

The Green Mountain Care Board

Alfred Gobeille, Chair; Karen Hein, M.D.; Cornelius Hogan; Betty Rambur, Ph.D., R.N.; Allan Ramsay, M.D.

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January 15, 2014

Sen. Claire Ayer, Chair, Senate Health and Welfare Committee
Rep. Mike Fisher, Chair, House Health Care Committee
Rep. Martha Heath, Chair, Joint Fiscal Committee
Sen. Jane Kitchel, Vice-Chair, Joint Fiscal Committee
State House
Montpelier, VT 05633

Dear Senator Ayer, Representative Fisher, Representative Heath, and Senator Kitchel:

Please accept the annual report of the Green Mountain Care Board, as required by 18 V.S.A. § 9375 (d). As explained in our December 13, 2013 letter to the Joint Fiscal Committee, this publication also provides the GMCB cost shift information for 2013. We will be happy to provide your committees with greater detail on the cost shift as more information becomes available.

Our Board places the highest value on accountability, and we appreciate this annual opportunity to publicly take stock of our progress and our plans. We prepared this report mindful of both the specific statutory requirements of the report and any questions we might expect Legislators and citizens of Vermont to have about the roles, progress, and priorities of our Board.

We wish to thank the many people who devoted their time, energy, and creativity to the work described in these pages. While the GMCB's role is uniquely independent, we simply could not have achieved what we have—nor could we hope to reach our ambitious goals—without the dedicated collaboration of people who every day bring the whole range of perspectives to the table with us.

We thank you, Vermont's Legislators, for your leadership and your support in achieving our shared goals for 2013. We look forward to continued collaboration in 2014.

Sincerely,

Alfred Gobeille
Chair

Contents

This report provides highlights of the activities of the Green Mountain Care Board for the calendar year 2013. We welcome your comments and questions. Reach us through the comment portal on our website (http://www.gmcboard.vermont.gov/publiccomments), via e-mail at GMCB.Board@state.vt.us, by calling 802.828.2177, or by attending our weekly public meetings.

Cover Art: Tim Newcomb. Photography: Jay Ericson and Alison Redlich. Editorial: Rick Blount.

Executive Summary

This Annual Report summarizes the role of the Green Mountain Care Board (the GMCB, or the Board), its progress in 2013, and its priorities for 2014. Vermont's Act 48 created the GMCB and set the state on a course toward a sustainable health care system that improves health and provides universal access to all Vermonters. The principles of Act 48 form the foundation for the truly coordinated system that Vermont's Legislature envisions in Vermont.

The GMCB has three fundamental roles in order to achieve the twin goals of improving health and moderating costs:

Regulation. By reviewing hospital budgets, Certificates of Need, and health insurance rates, the GMCB is both containing health care costs for Vermonters and drawing ever-tightening connections between these previously separate aspects of health care spending.

Innovation. Organizations serving Vermonters are collaborating on projects to test new ways to pay for and deliver health care. In its role of supervising these projects, the GMCB constantly stresses the importance of demonstrating true benefit to Vermonters.

Evaluation. Nowhere is the GMCB's status as an independent Board more important than in its evaluative role. While many of the projects testing ideas to improve health care payment and delivery are likely to prove beneficial, some may fall short of expectations. It will be necessary to measure and evaluate the full effects of changes—positive and negative, intended and unintended. This role is of increasing importance as Vermont moves toward Green Mountain Care in the next few years.

Progress in 2013

Highlights of 2013 included:

- The GMCB's second round of annual budget reviews resulted in hospital budget growth of 2.7 percent, the lowest rate in Vermont in at least the past 15 years.
- The GMCB monitored the "cost shift," reported its findings to the Legislature, and factored the findings into hospital budget review.
- In its first year overseeing the Certificate of Need (CON) process, the Board issued four CONs and one Conceptual Development Phase Certificate of Need (CCON).
- The GMCB issued 31 health insurance rate decisions. These included the first-ever rates for health insurance plans offered through Vermont Health Connect, the state's online health insurance exchange. The Board carved approximately 5 percent off the rates proposed by BlueCross BlueShield of Vermont (BCBSVT) and MVP Health Care (MVP).
- Vermont's program for testing new ways to pay for and deliver health care gained ground in 2013 with the launch of new projects, the establishment of work groups to create standards and measures that ensure that any changes result in demonstrable

benefits for Vermonters, and progress on analyses of price variation and the impact of insurers' requirements for prior authorization.

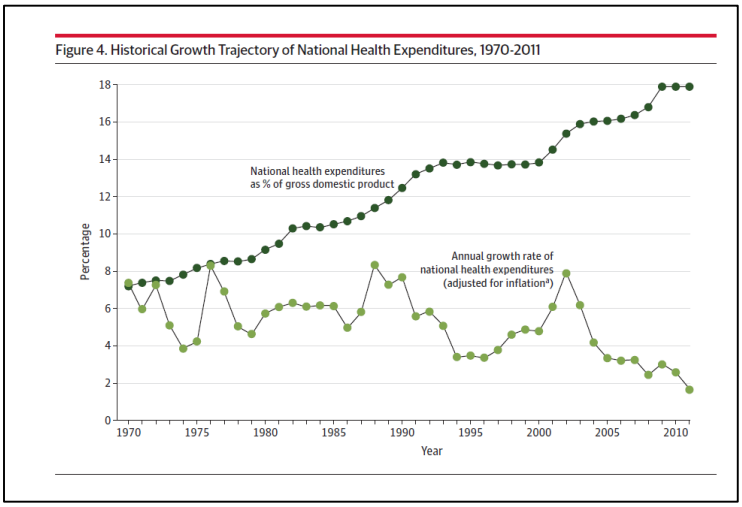
- Thanks to a diverse group of public/private stakeholders, the $45 million State Innovation Model (SIM) grant has taken shape with an operational plan, work groups with hundreds of participants from the public and private sectors, and a new name: The Vermont Health Care Innovation Project (VHCIP).
- The GMCB took significant steps toward improving Vermont's systems for tracking and analyzing health care spending, evaluating the impact of cost containment activities, and examining the feasibility of future financing plans for Vermont's health care system.
- The pace of activity on Public Health Improvement/Population Health quickened in 2013, guided by a new work group on the topic.
- The GMCB continued to broaden the definition of health "benefits," commissioning a study of Vermonters' oral health needs.
- The GMCB approved the Administration's Workforce Strategic Plan.
- The GMCB took its weekly public meetings on the road, with Traveling Board Meetings in Bennington, Newport and Rutland, while individual Board members logged more than 60 speaking engagements.
- With the Department of Financial Regulation, the GMCB leveraged grant funding to successfully launch a new health insurance rate review web site.

Priorities for 2014

- **Regulation:**
  - Maintain downward pressure on health care costs.
  - Further integrate regulatory systems so that each cycle of each regulatory task fits into a broader context to serve Vermonters.
- **Innovation:**
  - Continue to refine and expand opportunities to test improvements in health care payment and delivery.
  - Identify and address areas of the health care system, such as mental health/substance abuse, that may not have traditionally received equitable attention and support in payment and delivery reform efforts.
  - Continue to integrate Public Health Improvement/Total Population Health strategies.
- **Evaluation:**
  - Continue to improve our ability to accurately and objectively monitor, evaluate, and report on Vermont's health care system.
  - Evaluate and share results of health care innovation efforts.
  - Clarify, communicate about, and plan for adequate support of the GMCB's evaluative duties with regard to Green Mountain Care.

Act 48 and the Role of the GMCB

For the past half century, the cost of health care has consistently risen at a steeper rate than inflation. This remains true despite much-publicized reductions in the rate of growth in health spending in recent years. By 2011, health care spending accounted for 18 cents of every dollar spent in the U.S. – and 20 cents of every dollar spent in Vermont.



From "The Anatomy of Health Care in the United States," Journal of the American Medical Association, November 12, 2013

Vermont's Act 48 created the GMCB and set the state on a course toward a sustainable health care system that improves health and provides universal access to all Vermonters. The principles of Act 48 form the foundation for the truly coordinated system Vermont's Legislature envisions in Vermont. These principles guide the GMCB's work, as detailed in *Appendix B*.

In the GMCB's first two full years of operation, the Board has taken every opportunity to promote the collaboration, communication, and commitment to Vermonters that will help define a highly functioning system.

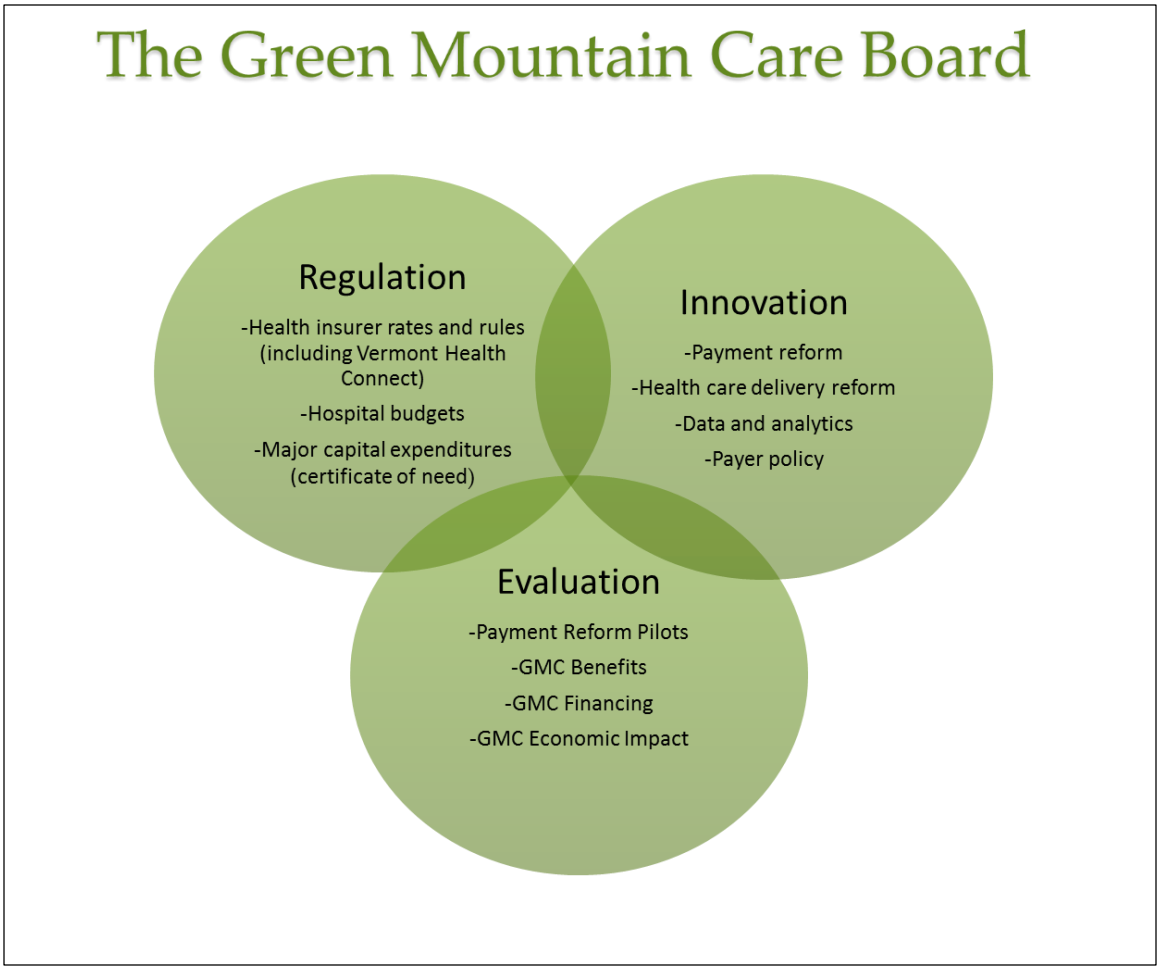
This "word cloud" illustrates the frequency of words used in the principles of Act 48.

These formative years have included notable achievements, especially in containing hospital budgets and insurance rates. Perhaps more importantly, the GMCB has established processes and tools to guide the significant system-building work that will lay the groundwork for implementing Green Mountain Care.

The Legislature has assigned the GMCB new responsibilities regarding health insurance rate review and oversight of health data beginning in 2014. Taken together with the responsibilities previously assigned to the GMCB by Act 48, these additions provide the GMCB the perspective, the information, and the leverage to accelerate progress toward a systematic approach to health care in Vermont.

The GMCB has three fundamental roles in order to achieve the twin goals of improving health and moderating cost:

- Regulation
- Innovation
- Evaluation



Regulatory responsibilities

Capital expenditures such as new buildings and high-tech imaging machines affect hospital budgets, which in turn affect insurance premiums. Part of what's novel about the GMCB's role is that Vermont has now established one entity responsible for regulating this whole range of interdependent activities.

After two cycles of regulating hospital budgets and health insurance rates, and one cycle of reviewing Certificate of Need applications for major capital spending, the GMCB is both containing health costs for Vermonters and drawing ever-tightening connections between these previously separate aspects of health care spending.

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The GMCB's priorities reflect a growing desire to integrate the state's health planning in all of these areas so that the whole picture of health care costs comes more sharply into focus. This work is supported by development of data and reporting systems and by activity in the innovative and evaluative roles.

Innovation responsibilities

Supervised by the GMCB, a range of organizations serving Vermonters are collaborating on projects to test new ways to pay for and deliver health care. These projects are described in the *GMCB Progress in 2013* section of this report.

The pace of innovation in Vermont's health system provides reason for both optimism and careful monitoring. It is encouraging to see the rise of projects involving creativity and collaboration among organizations that serve the health care needs of Vermonters. At the same time, it is vital that any innovations, no matter how good they look on paper, are introduced in ways that allow for careful examination of whether or not the changes benefit Vermonters. This necessity drives the GMCB's role in innovation, as well as our evaluative role.

A range of organizations serving Vermonters are collaborating on projects to test new ways to pay for and deliver health care.

A key area of innovation that underlies all of the GMCB's work is the development of new and better data systems. In 2013, the GMCB's hospital budget team successfully launched an online hospital budget tool. The finance departments from all 14 of the state's hospitals entered their

data into this system, which provided the GMCB with data that was organized in standardized ways, allowing for much easier "apples-to-apples" comparisons for these complex budgets.

The GMCB is committed to driving more of this kind of innovation to support all of its work.

Evaluative responsibilities

Nowhere is the GMCB's status as an independent board more important than in its evaluative role. While many of the projects testing ideas to improve health care payment and delivery are likely to prove beneficial, some may fall short of expectations. It will be necessary to measure and evaluate the full effects of changes—positive and negative, intended and unintended. This role is of increasing importance as Vermont moves toward Green Mountain Care in the next few years.

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At this point in the implementation of Act 48, the GMCB's evaluative role plays out mostly in the mandate to analyze outcomes of reform projects in health care payment and delivery. Moving forward, the GMCB will be placing greater emphasis on preparing for crucial evaluative roles related to Green Mountain Care's benefits, financing, impacts, and sustainability.

Remembering our purpose

Guided by Act 48 and subsequent legislation, the GMCB is working toward a true system of health care in Vermont that improves Vermonters' health by achieving these goals:

- Promoting access to health care.
- Improving the quality of health care Vermonters receive, as judged by both medical experts and by patients.
- Making costs understandable, equitable, and affordable.

GMCB Progress in 2013

For the GMCB, 2013 was a year of both accomplishment and significant transition. Certain milestones sped the process along:

- Vermont received a $45 million federal State Innovation Model grant, which is now known as the Vermont Health Care Innovation Project (VHCIP).
- The Board saw its first transition in leadership and membership. Board member Al Gobeille was appointed Chair; Betty Rambur, Ph.D., R.N. joined the Board; and Susan Barrett, J.D. was chosen as Executive Director. The transitions occurred when founding Chair Anya Rader Wallack, Ph.D., and Executive Director Georgia Maheras accepted roles related to the VHCIP.
- After the launch of a new online hospital budget tool helped the GMCB set and track three-year budget targets, the state's hospital CEOs and their CFOs sharpened their pencils in a process that yielded historically low budget increases.
- The Legislature helped address the cost shift and helped with the hospital budgeting process by increasing a 3 percent increase in Medicaid rates.
- The Legislature streamlined and expedited the health insurance rate review process, assigning the GMCB additional responsibility for a process intended to be transparent, participatory, and efficient.
- The GMCB met its regulatory role in approving benefit plans and insurance rates for Vermont Health Connect.

Punctuated by these events and many others, the GMCB's second full year featured progress in each of its three main areas of responsibility:

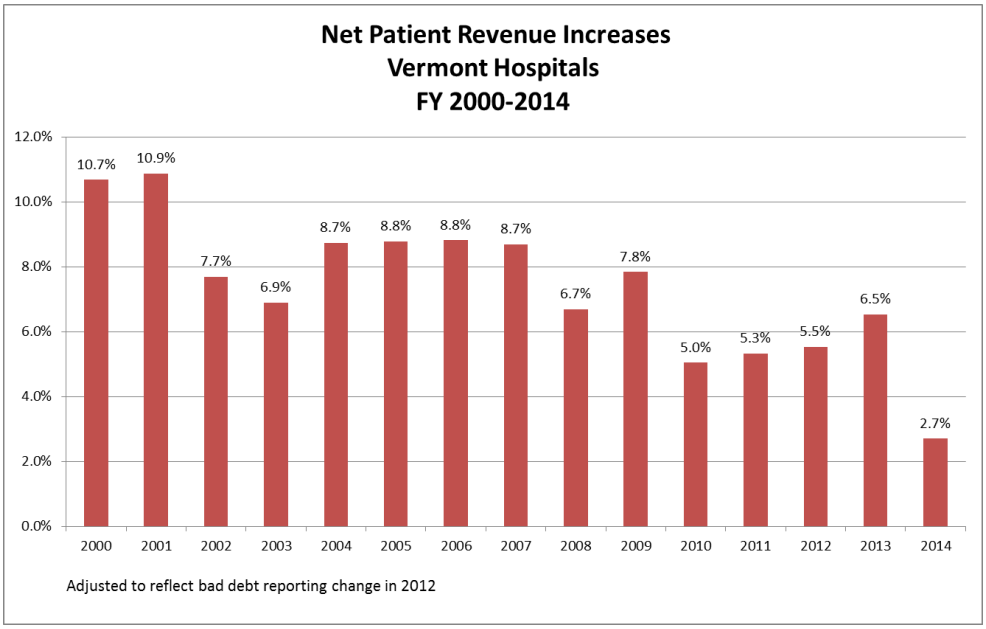
- Improved systems and principles to support **regulation.**
- A broadening network of public-private partnerships joining forces to drive **innovation**.
- Increasing attention to the GMCB role in the **evaluation** of two broad areas of health reform. This includes evaluating the success of efforts to test new methods of health care payment and delivery and evaluating the benefits and financing plans for, as well as the economic impacts of, the emerging Green Mountain Care health system.

The Board and staff are grateful to the many people from all over Vermont who took time from their busy lives to share their experiences and ideas: the dentist in Bennington, the developer in Newport, the laid-off educator in Barre, the opiate clinic administrators in Rutland, and so many others. You have helped us understand the needs, the hopes, and the concerns of Vermonters as we work toward a less-fragmented, more-affordable, higher-quality health care system. Your voices are essential to the evolution of the GMCB's work.

The following pages contain in-depth summaries of progress in each of our areas of responsibility in 2013.

Hospital Budgets

In September, the GMCB's second round of annual budget reviews resulted in the lowest rate of hospital budget growth in Vermont in at least the past 15 years. The following chart illustrates this accomplishment.



The lower budgets were achieved with the help of a review process that was improved after the GMCB's first year of budget review. The Board's expectations were spelled out for hospitals in March through written guidance addressing key elements of the budget:

- Each hospital's increase in net patient revenue was limited to a target of no more than 3 percent for each of the next three years. Net patient revenue includes payments from patients, government, and insurers for patient care—but not revenues from other sources such as cafeterias, parking, and philanthropy.
- For FY 2014, as much as one percentage point of additional growth in net patient revenue would be considered for "credible health reform proposals" to save money and improve care over the long term.
- Net patient revenue increases from hiring physicians already practicing in the community would not be counted against the targets if a hospital demonstrated that the change would be "revenue neutral." This means that dollars already being spent on health care in the community would simply move into the hospital budget.

The original submissions from Vermont's hospitals would have caused system-wide growth in net patient revenue (NPR) of 2.9 percent, with individual hospitals' budgets ranging from a decrease of 11.5 percent to an increase of 6.2 percent. After extensive review, public comment and testimony, the GMCB trimmed the system-wide growth to 2.7 percent. The following table shows the submitted and approved budgets.

Net Patient Revenue for Vermont Hospitals
FY 2013-2014

Hospital	Approved Budget 2013	Submitted Budget 2014	Submitted % Change	Approved Budget 2014	Approved % Change
Brattleboro Memorial Hospital	$ 65,889,615	$ 69,957,064	6.2%	$ 69,793,064	5.9%
Central Vermont Medical Center	$ 155,378,089	$ 161,181,377	3.7%	$ 160,372,377	3.2%
Copley Hospital	$ 56,335,433	$ 57,795,625	2.6%	$ 57,795,625	2.6%
Fletcher Allen Health Care	$ 1,014,716,512	$ 1,063,141,724	4.8%	$ 1,059,369,710	4.4%
Gifford Medical Center	$ 62,965,572	$ 64,106,475	1.8%	$ 64,106,475	1.8%
Grace Cottage Hospital	$ 18,722,593	$ 16,560,535	-11.5%	$ 16,560,535	-11.5%
Mt. Ascutney Hospital & Health Center	$ 46,919,923	$ 46,900,850	0.0%	$ 46,900,850	0.0%
North Country Hospital	$ 75,876,293	$ 75,085,299	-1.0%	$ 75,085,299	-1.0%
Northeastern VT Regional Hospital	$ 62,276,100	$ 64,687,170	3.9%	$ 64,342,855	3.3%
Northwestern Medical Center	$ 83,550,542	$ 87,759,305	5.0%	$ 87,759,305	5.0%
Porter Medical Center	$ 68,848,517	$ 69,809,477	1.4%	$ 69,809,477	1.4%
Rutland Regional Medical Center	$ 211,476,550	$ 217,820,712	3.0%	$ 217,820,712	3.0%
Southwestern VT Medical Center	$ 149,179,382	$ 139,576,168	-6.4%	$ 139,576,168	-6.4%
Springfield Hospital	$ 51,874,106	$ 51,978,215	0.2%	$ 51,978,215	0.2%
Net Patient Revenue	$ 2,124,009,227	$ 2,186,359,995	2.9%	$ 2,181,270,665	2.7%

Along with curbing budget growth, Vermont's hospitals generally limited increases in their overall rates. Two moves by the State of Vermont should help in this effort by boosting the payments to hospitals for treating people covered by State health programs. In its latest session, the Vermont Legislature approved a 3 percent increase in Medicaid rates. In addition, Vermonters previously enrolled in Catamount are eligible to shop for private insurance on Vermont Health Connect (VHC) in 2014. See the table below for details of hospital rate changes.

Annual Overall Rate Increase for Vermont Hospitals
FY 2011-2014

	Approved Rate 2011	Approved Rate 2012	Approved Rate 2013	Submitted Rate 2014	Approved Rate 2014
Brattleboro Memorial Hospital	6.0%	7.4%	5.2%	6.2%	5.8%
Central Vermont Medical Center	5.2%	6.0%	5.0%	7.9%	6.9%
Copley Hospital	5.5%	6.0%	3.0%	6.0%	6.0%
Fletcher Allen Health Care	5.7%	5.9%	9.4%	4.5%	4.5%
Gifford Medical Center	5.8%	7.0%	6.1%	7.6%	7.6%
Grace Cottage Hospital	5.5%	10.6%	6.5%	6.0%	6.0%
Mt. Ascutney Hospital & Health Center	6.5%	3.5%	7.0%	5.0%	5.0%
North Country Hospital	4.4%	5.1%	4.6%	8.0%	7.3%
Northeastern VT Regional Hospital	4.8%	7.5%	6.5%	5.8%	4.4%
Northwestern Medical Center	1.8%	6.3%	2.9%	4.6%	3.9%
Porter Medical Center	6.5%	10.3%	5.0%	6.0%	6.0%
Rutland Regional Medical Center	5.5%	9.8%	10.3%	4.8%	4.8%
Southwestern VT Medical Center	6.0%	5.5%	6.8%	9.0%	7.2%
Springfield Hospital	3.8%	5.8%	6.0%	6.0%	4.6%
Vermont Community Hospitals *	5.45%	6.47%	7.94%	5.47%	5.14%

** Estimated weighted average*

Note that the tables presented above reflect budgets approved in September 2013. During the year hospitals sometimes request adjustments based on changing situations.

This year featured the successful launch of an online budgeting tool to allow in-depth" apples-to-apples" analysis of the 14 hospital budgets. This was also the first year hospitals were asked to submit their Community Health Needs Assessment reports, which are attached to hospitals' federal tax fillings as part of hospital budget filing. The Board is evaluating these filings to determine how they can best be used as part of the overall budget review process.

Cost Shift

The "cost shift" occurs when hospitals and other health care providers charge higher prices to patients who have private insurance or no insurance to make up for lower reimbursement from Medicare and Medicaid, charity care, or bad debt.

In 2006, Act 191 created the Cost Shift Task Force, which prepared a report describing the cost shift, quantifying its impact, and presenting reporting recommendations for an annual report to the Legislature that would include:

- A standard reporting instrument.
- Improvements to physician payer data.
- Distinctions between the amount of Vermont Medicaid and non-Vermont Medicaid payments.
- Increased transparency in reporting on "disproportionate share"—the Medicaid payments to hospitals that serve populations with especially high coverage by Medicaid.

The GMCB now creates the annual cost-shift report, filing its most-recent version with the Legislature in April 2013. For 2014, Act 79 added a requirement that this annual report include *"any recommendations on mechanisms to ensure that appropriations intended to address the Medicaid cost shift will have the intended result of reducing the premiums imposed on commercial insurance premium payers below the amount they otherwise would have been charged."* (18 V.SA. § 93751) (d) (1) (F). This section of the 2014 GMCB Annual Report is intended to provide the Board's 2014 cost shift report**.**

The GMCB recommends continuing to use the hospital budget process as the mechanism to ensure that appropriations have their intended results. For example, in the FY 2014 Hospital Budget filings the GMCB evaluated the individual rate increase for each hospital. This evaluation included a review of the revenue estimates for each payer, including Medicaid.

The GMCB's evaluation found that four hospitals did not factor the latest Medicaid estimate in their budget because they lacked sufficient data. As a result, the Board adjusted these hospitals' requested rates downward. With these adjustments, each hospital's Medicaid estimate was consistent with Department of Vermont Health Access (DVHA) estimates. The result was a Medicaid cost shift with virtually no increase over the prior year's budgets, as shown in the table on the next page. (Note that the table does in fact show a very slight increase from $152,943 to $153,210; this change of 0.2 percent is more likely an artifact of the complexity of the calculation than a real change in the cost shift.)

Community Hospital System
Vermont Hospital Payers Shifting Costs (in millions)

Hospital Fiscal Year	Medicare	Medicaid	Free Care	Bad debt		*Commercial Insurance & Other
ACT 08	($69,004)	($103,569)	($23,624)	($30,253)	-------->	$226,450
ACT 09	($73,627)	($119,979)	($24,292)	($32,391)	-------->	$250,290
ACT 10	($73,516)	($138,017)	($24,806)	($33,077)	-------->	$269,416
ACT 11	($88,400)	($152,257)	($25,784)	($34,331)	-------->	$300,772
ACT 12	($68,335)	($151,932)	($24,347)	($39,265)	-------->	$283,879
BUD 13	($138,906)	($152,943)	($24,265)	($40,008)	-------->	$356,122
BUD 14	($184,443)	($153,210)	($27,016)	($41,398)	-------->	$406,067

Payers' values include all hospital and employed physician services.

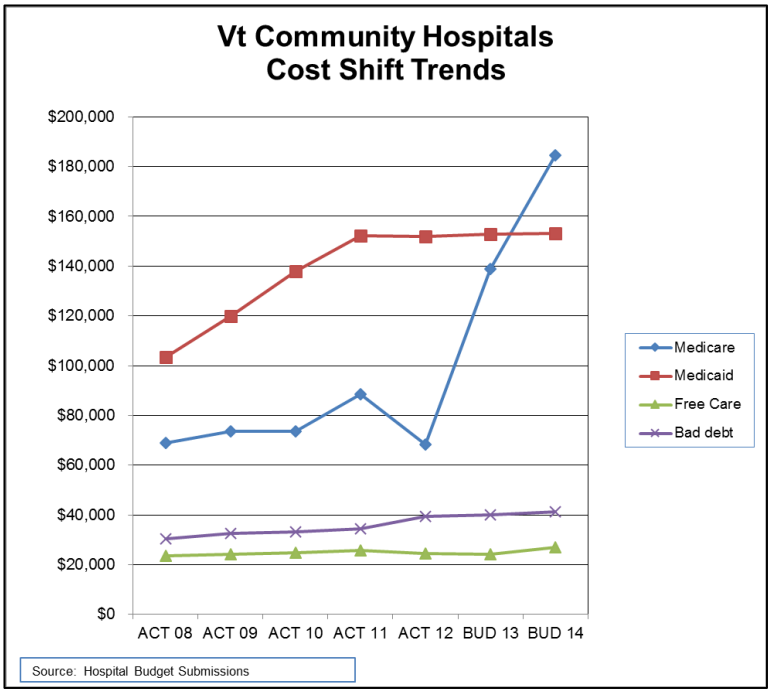
Numbers in parentheses reflect the estimated cost of services that each payer shifted to other payers.

Medicaid values include non-Vermont Medicaid of approximately 5%.

** The amount providers shifted to commercial insurance and self pays.*

As the table above and chart at right show, the Medicaid cost shift for hospitals has been essentially flat between 2011 and 2014: It is estimated at $152 million in 2011 and estimated at $153 million in 2014.

Despite the flat Medicaid trend, the total cost shift is still increasing, largely because Medicare budget estimates show a large increase expected in the Medicare cost shift for both 2013 and 2014. These estimates arise from reimbursement changes proposed at the federal level. The GMCB will be monitoring these changes going forward.



Certificate of Need

In its first year overseeing the Certificate of Need (CON) process, the GMCB issued four CONs and one Conceptual Development Phase Certificate of Need (CCON). Pursuant to 18 V.S.A. § 9434(c), a CCON must be secured to permit the applicant to make expenditures for planning and design activities for projects expected to exceed $30 million.

After extensive analysis and public input, the Board approved:

- The sale of Crescent Manor skilled nursing facility in Bennington for $4,400,000.
- Replacement of an MRI unit at Fletcher Allen Health Care for $2,362,828.
- Relocation and renovation of Fletcher Allen Health Care's Mother Baby Unit, which also includes the relocation and renovation of the General Clinical Research Center for $15,828,164.
- Relocation of Gifford Medical Center's existing 30-bed skilled nursing facility to property owned by the hospital in Randolph Center, and conversion of the vacated space to accommodate single occupancy inpatient rooms for the medical/surgical transitional care and birthing unit for $12,665,270.
- Fletcher Allen Health Care's request for a CCON for $3.7 million to perform detailed planning and design work in anticipation of replacing a portion of its inpatient bed capacity. Before beginning the project, estimated to cost in excess of $85 million, Fletcher Allen is expected to return to the Board with a CON application.

Applications are pending for two CONs:

- The sale of Newport Health Care Center and Newport Residential Care Center, an existing skilled nursing facility, to Newport Rehabilitation and Nursing Center, LLC and Newport RNC Realty, LLC, both Delaware corporations.
- Pathways Vermont's request to create Soteria Vermont, a five-bed residence in Burlington for adults experiencing a first episode of psychosis.

CON jurisdiction has been asserted in the following instances, but applications have not yet been filed:

- Copley Hospital: construction of a new operating room suite.
- Rutland Area Visiting Nurse Association and Hospice: purchase of the Bennington Home Health and Hospice Agency.

In addition, Maple Leaf Farm withdrew its application to purchase the former Pine Ridge School in Williston due to its concern about financial issues and non-CON permitting delays. The Board also reviewed jurisdictional requests in which it was determined that the projects did not trigger thresholds requiring CON review.

Insurance Rates

In July 2013, the GMCB announced decisions on the first-ever rates for health insurance plans offered through Vermont Health Connect, the state's online health insurance benefit exchange. The Board issued two decisions—one for each of the two carriers offering plans through the exchange—that carved approximately 5 percent off the rates proposed by BlueCross BlueShield of Vermont (BCBSVT) and MVP Health Care (MVP).

The Vermont Health Connect rates approved by GMCB result in an estimated premium of approximately $400 per month for a single person purchasing the benchmark "silver plan," with higher or lower premiums depending on choice of "metal level." Following the GMCB's rate decisions, the Commissioner of the Department of Vermont Health Access approved 18 plans to be offered on Vermont Health Connect; BCBSVT and MVP each offer standard plans in the platinum, gold, silver and bronze metal levels, a high deductible silver and high deductible bronze plan, and three non-standard "Choice" plans. The non-standard plans are unique to each carrier, and have features that enhance the value of the benchmark benefits offered in the standard plans. Significantly, many Vermonters will be eligible for new federal and state tax credits which will reduce their premium payments below those approved by the GMCB.

The Board also issued a decision in July reducing BCBSVT's proposed 24.4 percent increase in rates charged to approximately 15,000 Vermonters enrolled in the Catamount health plan during the third and fourth quarters of 2013—the final time period for the Catamount program. The Department of Financial Regulation (DFR) recommended that the Board order the carrier adjust the rates in several ways, lowering the increase to 13.9 percent; the Board accepted the recommendation, but ordered additional adjustments that reduced the rate increase to approximately 11.9 percent.

The Board issued 31 decisions in 2013. Details of the filings resulting in changes to premiums or the "trend factor" that influences premiums are provided in the table on page 15. Highlights include:

- Reducing BCBSVT's requested small group rate increase for the last three quarters of 2013.
- Reducing the requested administrative charge expenses and contributions to surplus for BCBSVT and The Vermont Health Plan (TVHP) for the fourth quarter of 2013 through the third quarter of 2014.
- Modifying large claims pooling factor filings for BCBSVT and TVHP.
- Disapproving a 15 percent increase in BCBSVT Safety Net rates for the final two quarters of 2013. (The Safety Net plan has experienced declining membership and will no longer be available in 2014).
- Disapproving TVHP's proposed 20.7 percent average rate increase for small group members renewing coverage in the third quarter of 2013, and 18.4 percent average increase for members renewing in the fourth quarter. In its decision, the Board cited declining utilization and TVHP's profitability.

In 2014, two developments are bringing significant changes to the rate review process:

- The Legislature expanded the jurisdictional role of the GMCB starting January 1, 2014, simplifying and shortening the existing two-step review process. (*See* 2013, No. 79, § 5c.) Currently, the Department of Financial Regulation (DFR) reviews rate requests on their submission and recommends that the GMCB approve, modify, or disapprove of the requests. In 2014, the GMCB will assume primary responsibility for this process, with DFR providing the GMCB with a solvency analysis only. A new web site launched on January 1 informs Vermonters about the new streamlined health insurance rate review process and provides expanded access for those who wish to become involved in the process. This includes the ability to sign up for notifications of new rate filings.

- With the Vermont Health Connect insurance plans beginning coverage in 2014, some of the existing plans being reviewed by the Board will end, and consumers will migrate from those plans to plans offered through Vermont Health Connect. As a result, each insurer will make fewer filings in 2014 than in previous years.

2013 Green Mountain Care Board Health Insurance Rate Decisions

Company Name*	Type of Filing	Approved Effective Date	Rate Change Requested (average)	Rate Change Approved (average)	# of Affected Members
BCBSVT	2013 VT Education Health Initiative	3Q13-2Q14	12.80%	9.50%	42,188
BCBSVT	Nongroup	1Q13, 2Q13, 3Q13	11.4%, 19.6%, 19.5%	Disapproved	1,026
TVHP	Small Group	1Q13, 2Q13	9.2%, 15.7%	7%, 7%	21,853
BCBSVT	Small Group	1Q13	12.40%	12.40%	1,075
MVP	Large Group PPO/EPO	3Q13, 4Q13	5.7%, 3.1%	5.7%, 3.1%	1,792
MVP	Small Group PPO/EPO	3Q13, 4Q13	13.5%, 13.0%	10.5%, 10.0%	4,025
MVP	Large Group HMO	3Q13, 4Q13	7.60%	7.60%	9
MVP	Small Group HMO	3Q13, 4Q13	7.8%, 8.0%	7.8%, 8.0%	61
MVP	Nongroup	3Q13, 4Q13	13.3.% Grandfathered, 14% Non-grandfathered, 5.4%	13.3.% Grandfathered, 14% Non-grandfathered, 5.4%	1,142
BCBSVT	Trend Factor	3Q13, 4Q13	Combined: 5.1%	Combined: 3.8%	14,664
TVHP	Trend Factor	3Q13, 4Q13	Combined: 6.1%	Combined 4.6%	NA
MVP	2014 VT Health Exchange	2014	New Rate	Reduced requested rate by approximately 5.3%	NA
BCBSVT	2014 VT Health Exchange	2014	New Rate	Reduced requested rate by approximately 4.3%	NA
BCBSVT	Catamount	3Q13, 4Q13	24.40%	11.90%	15,351
BCBSVT	Small Group	2Q13, 3Q13, 4Q13	-3.69%	-5.70%	12
BCBSVT	Safety Net	3Q13, 4Q13	15%	Disapproved	217
TVHP	Admin. Trend and Contrib. to Reserve	3Q13-3Q14	1.7% admin., 2% reserve	0% admin, 1% reserve	NA
BCBSVT	Admin. Trend and Contrib. to Reserve	3Q13-3Q14	1.7% admin., 2% reserve	0% admin, 1% reserve	NA
TVHP	Small Group	3Q13, 4Q13	20.7%, 18.4%	Disapproved	2,132
MVP	Grandfathered Small Group EPO/PPO	1Q14, 2Q14	10.4%, 10.3%	3.4%, 3.3%	3,756
MVP	Grandfathered Nongroup Indemnity	1Q14, 2Q14	0%, 0%	(-5.3%), (-5.3%)	1,246
MVP	Agriservices	2013	5.10%	3.60%	1,538
MVP	Large Group PPO/EPO Manual Rate	1Q14, 2Q14	5.90%	3.90%	6,234
MVP	Large Group HMO Manual Rate	1Q14, 2Q14	4.40%	2.70%	416
BCBSVT	Vermont Auto Dealers Association	2013	1.90%	1.90%	2,301

**** BCBSVT: Blue Cross Blue Shield of Vermont; MVP: MVP Health Care; TVHP: The Vermont Health Plan.***

This table includes GMCB decisions that resulted in changes to premiums or to the "trend factor" that influences premiums.

Payment & Delivery System Reform

Vermont's efforts to drive innovation in the state's health care payment and delivery systems got a major boost in 2013 with the news that the state received a federal State Innovation Model (SIM) testing grant, which is discussed in detail in the next section. This grant supports the design and testing of three specific payment models: population based payments through a Shared Savings Program between Accountable Care Organizations (ACOs) and payers; Bundled Payments; and Pay for Performance. Each of these payment models will be developed, implemented, and evaluated with the involvement of a broad group of public and private stakeholders.

In collaboration with the SIM grant team and stakeholders from around Vermont, the GMCB is encouraging a wide range of efforts that test various models for innovation in payment and delivery.

The Vermont Blueprint for Health

Launched in 2003 as a Governor's Initiative and considered the foundation for Vermont's health payment and delivery reform models, the Blueprint for Health now includes more than 450,000 Vermonters. The model promotes advanced primary care in the form of Patient Centered Medical Homes (PCMHs), multi-disciplinary support services in the form of Community Health Teams (CHTs), and a network of self-management support programs. All major insurers in Vermont participate in payment reforms designed to support the PCMH and CHT operations.

The GMCB believes this program can lead to several important outcomes, including an increase in the rate at which people receive recommended assessments and treatments, a reduction in avoidable acute care, and improved control over the growth in healthcare costs. The GMCB considers the Blueprint/PCMH model to be an important delivery system innovation and therefore participates in the evaluation of the program. This year the Blueprint will provide results of a study comparing 2012 Blueprint participants with a comparison group using the Vermont Healthcare Claims Uniform Reporting and Evaluation System (VHCURES), which is the most complete source of claims data across all settings and insurers in Vermont. This evaluation is designed to determine whether the Blueprint program is achieving the desired goals of health care reform.

Shared Savings Programs

From December 2012 through October 2013, the GMCB and the Department of Vermont Health Access (DVHA) convened two work groups to support the creation of Medicaid and Commercial Accountable Care Organization (ACO) Shared Savings Programs (SSPs) modeled on Medicare's ACO SSP. These work groups met twice monthly throughout the year, and included representatives of ACOs, payers, hospitals, Federally Qualified Health Centers, physicians,

consumers, and others. To ensure that SSPs meet their intended purpose of benefitting Vermont consumers, careful monitoring of consumer impacts will evaluate key quality and access measures.

The **ACO Standards Work Group** was formed to develop standards for the Medicaid and Commercial SSPs. The Work Group drafted standards in the following areas:

- Standards related to the ACO's structure:
    - Financial stability.
    - Risk mitigation.
    - Patient freedom of choice.
    - ACO governance.

- Standards related to the ACO's payment methodology:
    - Patient attribution methodology.
    - Calculation of ACO financial performance and distribution of shared savings payments.

- Standards related to management of the ACO:
    - Care management.
    - Payment alignment.
    - Data use.

These Standards were presented to the Vermont Health Care Innovation Project VHCIP (formerly SIM) Steering Committee and Core Team and the GMCB for approval, and were adopted in December.

The **ACO Measures Work Group** was formed to identify standardized measures to evaluate the performance of Vermont's ACOs, and to develop a measures scoring process to determine how ACO performance influences the amount of savings that would be distributed to the ACO. To that end, the Work Group developed the following measure sets:

- Measures for **payment**; how the ACO performs on the measure may impact the amount of shared savings that the ACO receives.
- Measures for **reporting;** the ACO's performance on these measures will not impact the amount of shared savings that the ACO receives, but whether or not the ACO reports on the measure may impact shared savings.
- Measures for **monitoring and evaluation**, including key utilization indicators and other statewide quality measures.
- **Pending** measures for future consideration.

Through a collaborative process of carefully selecting and discussing each potential measure, the Work Group recommended Year One (2014) payment and reporting measure sets to the Vermont Health Care Innovation Project Steering Committee, Core Team, and the Green Mountain Care Board (GMCB) for final approval. The work group also recommended Year One scoring processes. These measure sets and scoring processes were adopted in December.

Standards and measures are aligned among commercial payers and Medicaid where possible, but are adapted as needed to reflect differences in the populations served by these two types of payers.

Other Payment and Delivery System Reform Initiatives

In addition to the Shared Savings Programs described above, the GMCB supports several current and proposed payment and delivery system reform initiatives throughout Vermont, including ACOs, the Vermont Oncology Project, the Rutland Medicare Congestive Heart Failure Bundled Payment Pilot, the Northwestern Medical Center Emergency Department Pilot, and the National Surgical Quality Improvement Program.

Accountable Care Organizations: Vermont has three Accountable Care Organizations, voluntary coalitions of providers intended to improve coordination and quality of care for patients and implement payment reforms (including Shared Savings Programs):

> **Accountable Care Coalition of the Green Mountains** (ACCGM) includes approximately 100 primary care and specialist physician members of Health First, a statewide Independent Practice Association (IPA). ACCGM is participating in the Medicare SSP, and is likely to participate in Vermont's Commercial SSP.
>
> **Community Health Accountable Care** (CHAC) is a joint venture between Bi-State Primary Care Association and five of Vermont's Federally Qualified Health Centers (FQHCs). In December 2013, CMS approved CHAC to participate in the Medicare SSP.

Also through CHAC, seven FQHCs are likely to participate in Vermont's Commercial and Medicaid SSPs.

OneCare is a statewide ACO consisting of a variety of outpatient providers, all of the state's community hospitals, Fletcher Allen Health Care, and Dartmouth-Hitchcock Medical Center. It is participating in the Medicare SSP and is likely to participate in Vermont's Commercial and Medicaid Shared Savings Programs.

Vermont Oncology Project: In **St. Johnsbury**, participants in The Vermont Oncology Project are identifying additional areas for improved provider communications, collaboration, and coordination of care for patients diagnosed with cancer. Participants in the project are also considering ways to streamline administrative processes with participating payers.

Congestive Heart Failure Bundled Payment Medicare Pilot: In **Rutland,** a project coordinating all care for Congestive Heart Failure (CHF) patients across several organizations and combining payment for that care now includes approximately 80 Medicare beneficiaries. CHF all-cause 30-day readmission rates are now averaging 12 to 13 percent for these patients, well below their historical rates of 24 to 25 percent. Project leaders presented their success story to the GMCB at a traveling board meeting in Rutland. Other providers around the state have noticed Rutland's success and have expressed interest in replicating the project in their regions.

Emergency Department Pilot: In **St. Albans,** Northwestern Medical Center's Emergency Department pilot focuses on reducing avoidable visits by enhancing care coordination and working with primary care physicians in the community was presented at a GMCB meeting in August. The GMCB approved the pilot with contingencies regarding the need for continued discussions with Medicaid and commercial payers around how savings would be shared. These discussions are ongoing.

National Surgical Quality improvement Program: The GMCB is facilitating discussions between surgeons and hospitals to encourage **statewide** participation in the American College of Surgeons National Surgical Quality Improvement Program (ACS NSQIP). ACS NSQIP is a nationally validated program that supports hospitals and surgeons in measuring and improving the quality of surgical care and outcomes for patients.

Prior Authorization Pilot: During the 2013 legislative session Act 79 included a prior authorization pilot program statute (18 V.S.A. § 9377a). The statute reads: "*The Green Mountain Care Board shall develop and implement a pilot program or programs for the purpose of measuring the change in system costs within primary care associated with eliminating prior authorization requirements for imaging, medical procedures, prescription drugs, and home care."*

With encouragement from the GMCB, the Vermont Medical Society conducted a study of the PA process that included a survey of 98 offices representing more than 400 primary care

providers in Vermont. Ninety-four percent of the survey respondents reported that the current PA process had a very or somewhat negative effect on their ability to treat patients.

The GMCB has also convened a prior authorization program work group to develop and implement pilot projects. The work group consists of representatives from the commercial insurers, Medicaid, consumers, and primary care providers as required by statute. Each group has a specific role in developing the pilot program to reduce the burden of prior authorization for primary care providers. The GMCB will act as a facilitator to help the commercial insurers and Medicaid implement the pilot. The GMCB will be responsible for the following:

1) Convene the workgroup at regular intervals and provide administrative support.
2) Participate in the pilot development process.
3) Provide guidance to the insurers related to implementation issues.
4) Assist in developing outcome measures related to quality and cost of care.
5) Analyze available data for the pilot and comparison groups.
6) Report progress on the Prior Authorization Pilot Program to the legislature.

Research Supporting Payment and Delivery System Reform. Several GMCB contracts support research to inform payment and delivery system reform. Research topics include:

> **Price Variation.** This project examines the variations in payments made by public and private payers to Vermont providers for similar services and will identify causes and potential impact of those payment differentials on payment reform initiatives. GMCB received a report for the first phase of this work at a June GMCB meeting. (View the report at http://gmcboard.vermont.gov/sites/gmcboard/files/Variation_Jun03.pdf.) GMCB has selected a vendor for the second phase of the project, which has just begun. It focuses on identifying the causes of the variation, and examining any potential policy options the GMCB might consider to reduce or eliminate these payment variations.
>
> **Promoting Best Practices.** In October, the GMCB heard an update on a contract with the Vermont Medical Society Education & Research Foundation for a project related to analysis of the use of CT scans for headache diagnosed in Vermont. The Vermont Radiological Association is also collaborating on the project, which is intended to reduce variation in care and promote best practices, while also validating the use of VHCURES data for such studies. The preliminary data indicate that, with some limitations, VHCURES data can provide useful insights into variations in care around the state. A detailed report is in the works.

More information on the programs described here can be found on the GMCB web site: www.gmcboard.vermont.gov.

SIM Grant/Vermont Health Care Innovation Project

Since being awarded in March and formally accepted by the State in May, the $45 million State Innovation Model (SIM) grant has taken shape with an operational plan, an array of work groups with hundreds of participants reflecting the project's public/private nature, and a new name: The Vermont Health Care Innovation Project (VHCIP).

Grant funds will be used to accomplish three major project aims: Improve care, improve population health, and reduce health care costs. Vermont's specific goals include:

- Enhancing the level of accountability for cost and quality outcomes among provider organizations.
- Creating a health information network that supports the best possible care management and assessment of cost and quality outcomes.
- Establishing payment methodologies across all payers that encourage the best cost and quality outcomes.
- Assuring accountability for outcomes from both the public and private sectors.
- Creating commitment to change and synergy between public and private culture, policies and behavior.

The VHCIP also includes oversight of the State's dual-eligibles financial alignment demonstration project. ("Dual eligibles" are people who qualify for coverage from both Medicaid and Medicare.) This will require better coordination of both care delivery and health care financing for Vermonters who are elderly and/or have chronic illnesses or disabilities. These populations experience some of the greatest gaps in care, diminished quality of services and potentially avoidable costs of care of all Vermonters.

The VHCIP's Operational Plan to achieve these goals was approved by the Centers for Medicare and Medicaid Innovation (CMMI) in September, allowing the State to begin testing three different payment models on October 1. (The plan can be found at http://gmcboard.vermont.gov/sites/gmcboard/files/Vermont%20SIM%20SIM_OPS_Plan_Oct2013.pdf).

The three-year multi-payer plan involves a process of testing the effectiveness of three alternative payment programs for Vermont's health care system:

- Shared Savings Accountable Care Organizations.
- Bundled Payments.
- Pay-for-Performance.

A key aspect of the Operational Plan is the governance process. It includes a Core Team, a Steering Committee and more than 300 stakeholders from across State government and the private sector participating in six Work Groups. GMCB Chair Al Gobeille serves on the Core Team and co-chairs the Steering Committee, while every GMCB board member and numerous staff are involved in committees. The Core Team provides overall direction, synthesizes and acts on guidance from the Steering Committee, sets project priorities, and helps resolve any conflicts within the project initiatives. The Steering Committee informs, educates and guides

the Core Team in all of the work planned under the VHCIP. In particular, the group will guide the Core Team's decisions about investment of project funds, necessary changes in State policy and how best to influence desired innovation in the private sector. The six Work Groups are:

- Payment Models Work Group.
- Care Models and Care Management Work Group.
- Duals Demonstration Work Group.
- Health Information Exchange Work Group.
- Quality and Performance Measures Work Group.
- Population Health Work Group.

Another related Work Group with support from the grant—the Health Care Workforce Work Group—was established by the Governor through Executive Order.

Work Groups will have specific charters related to their scope of work and expected deliverables, which will take the form of recommendations to the Steering Committee and Core Team. Work Groups will be responsible not only for their own scope of work but, to a significant degree, for coordinating with other work groups to develop joint recommendations to the Steering Committee on cross-cutting issues related to care models, payment models and quality measures.

More information on the programs described here can be found on the GMCB web site (www.gmcboard.vermont.gov) and at the Vermont Health Care Innovation Project web site launching early in 2014.

Health Care System Analysis & Reporting

In 2013, the GMCB took significant steps toward improving Vermont's existing systems for tracking and analyzing health care spending, for evaluating the impact of the cost containment activities that are being tested in the state, and for examining the feasibility of future financing plans for Vermont's health care system. The Board assumed statutory responsibility for the Vermont Healthcare Claims Unified Reporting and Evaluation System (VHCURES) and pursued contracts with expert vendors to help improve the information available in VHCURES and to perform the analyses detailed in the GMCB Data Analytic Plan. The Board consulted with these experts in health economics and health care data sets to ensure that the state has the appropriate tools and information to accurately track changes in key indicators of progress toward the goals of Act 48. These strategic steps enhance the state's capacity for a cohesive approach to ongoing health care system innovation, regulation, and evaluation.

VHCURES

In 2013, the GMCB led a public process to revise the state rule governing reporting requirements for VHCURES. Broad notification of diverse stakeholders resulted in a well-attended public meeting on September 25 to review proposed changes to the rule and gather feedback. GMCB staff are meeting with commercial insurers, Medicaid, and data users to develop specifications for program changes and rule amendment. The first draft of the proposed rule amendment will be available for public comment early in 2014. The contract for data collection and management of the VHCURES Database will expire in August 2014 and the GMCB must enter into a competitive bid process to select the future vendor. The GMCB is working with the Department of Information and Innovation (DII) to identify a project manager and develop a RFP for VHCURES that meets with State requirements and improves the system based on what has been learned about both its strengths and limitations. In November, the Medicare data licensed to the GMCB was delivered to Onpoint Health Data, the current VHCURES vendor. These data are being prepared for re-release to Truven Health Analytics and Brandeis University, who have been awarded GMCB contracts for a broad range of analytical services requiring specialized expertise.

Truven and Brandeis will help the state identify and evaluate targeted strategies to reduce the rate of growth in health care costs while improving the health of the Vermont population in ways that do not compromise health care quality. Project analysts will explore cost trends, profile subpopulations, measure health status and its relationship to spending, benchmark Vermont health spending against regional and national experience, and model the impact of future policy changes. The contractors will also assist the Board with standardizing, organizing, and managing Vermont health care data to afford more ease and transparency for future analyses and system evaluation, including evaluation of the initiatives in the VHCIP, also known as the SIM grant. The GMCB expects to see initial reports on these issues in the spring of 2014, with additional reports to follow through May of 2015.

Health Expenditure Analysis

Since 1993, Vermont has created an annual Health Care Expenditure Analysis. The FY 2012 Health Care Expenditure Analysis is under development and expected early in 2014, so the final FY 2011 analysis remains the most-current official data. The analysis is available at http://gmcboard.vermont.gov/sites/gmcboard/files/2011_Expenditure_Analysis_42313.pdf. The Expenditure Analysis summarizes data in two forms: the Resident Analysis includes expenditures on behalf of Vermont residents, regardless of where the health care was provided; the Provider Analysis includes all revenue received for services by Vermont providers, regardless of where the patient lives. One significant enhancement for the FY 2012 ongoing analysis will be to integrate claims data from VHCURES into the Vermont Health Care Expenditure Analysis. Truven Health Analytics and Brandeis University will incorporate claims data into the expenditure analysis in order to provide more detail on member demographics, utilization, and spending that includes commercial and government payers.

Forecasting & Analyzing Trends

As the Board improves its capability for understanding the health system as a whole, it is simultaneously encouraging and supervising system changes that must be accounted for in its analysis. To that end, the Board has contracted with Wakely Consulting Group to develop medical trends and to forecast medical expenses for payment reform pilots. This work will ensure that the medical trends that are projected for Vermont reflect payment reform contractual relationships, cost structure changes, medical management protocols, changes in member cost-sharing, and changes in the underlying population and state and federal policy decisions. While Wakely's work takes into account multiple changing factors that influence health care costs and spending, the Board as a central regulatory agency is also well positioned to incorporate multiple layers of information about the health care system into one coordinated approach to health care reform.

Health System Dashboard 2.0

In keeping with the Act 48 requirement to evaluate the performance of Vermont's health system, the GMCB launched "GMCB Health System Dashboard 1.0" in August, 2012. This first iteration presents easy-to-understand analysis of data on 26 key indicators in four critical areas: cost, access to care, healthy lives, and prevention and treatment. It can be found at http://www.gmcboard.vermont.gov/dashboardproject.

Work on GMCB Dashboard 2.0 began in August 2013 and is expected to be complete by mid 2014. It will incorporate input and guidance from the GMCB and Dashboard Stakeholder Group in order to accomplish the following:

- Identify dashboard indicators that are accessible to health care consumers.
- Align with measures reported elsewhere and/or use existing data streams.
- Include the most currently available data.
- Align with the goals for the GMCB Dashboard.

Unified Health Care Budget

Originally intended to create a global budget for all health care expenditures in Vermont, the Unified Health Care Budget (UHCB) has been part of Vermont law since 1993. While used in other countries to plan for, allocate, and constrain total health care expenditures, the UHCB has not played such an extensive role in Vermont. In 2013, the GMCB took a solid step toward testing part of such a role by setting three-year budget growth targets for the state's hospitals, which then held their budget growth well below recent trends.

In December, consultant Bob Murray told the Board that Vermont is one of only three states positioned to pursue pilot projects for global budgeting that would include all payers—governmental and private. The GMCB is currently working with two hospitals—Rutland Regional Medical Center and Southwest Vermont Medical Center in Bennington—on possible global budgets for their services, and other hospitals have expressed interest.

Public Health Improvement/Population Health

Following a December 2012 presentation on incorporating public health improvement into the GMCB's work, the pace of activity on public/population health quickened in 2013. To meet the goal of reducing cost, improving quality, and improving health, the GMCB remains focused on the non-clinical social, economic and behavioral determinants of health as well as the inclusion of primary prevention efforts that address total population health. Together with the Vermont Department of Health and others, the GMCB has continued to gather information and experience from State and national experts such as the Institute of Medicine and the Centers for Disease Control to facilitate the integration of total population health into GMCB's regulatory and innovation activities.

The goal of integrating total population health into Vermont's health care reform efforts is also being advanced by the Population Health Work Group created as part of the VCHIP. Co-chaired by Board member Karen Hein, M.D., the group in October proposed a charter establishing that it "will be a resource for the other VHCIP work groups and advise them on ways that their work can incorporate population health principles and contribute toward improving the population health of Vermonters."

Public health is a prominent item on broader agendas as well. In July, the National Governor's Association (NGA) convened a Technical Assistance meeting for Vermont around public health in the VHCIP. This meeting brought together representatives from federal agencies and in-state and external state stakeholders–including representatives from BCBSVT, MVP and Medicaid as well as those from the Department of Health, consumer groups and the GMCB. This Technical Assistance group provides the core of the VHCIP work group on population health. Several next steps were identified for future work by the population health work group and for additional

technical assistance from NGA. These could include working with interested communities in Vermont interested in pursuing this concept, identifying and integrating metrics from the individual to the statewide population level, and ensuring all relevant VHCIP work groups include population health representation to ensure the planning includes this perspective.

Benefits

In fall 2012, the GMCB approved the health care services that insurers are required to cover as part of plans offered on Vermont Health Connect. When the GMCB approved these "Essential Health Benefits," the Board recognized the need to obtain more information about Vermonters' oral health needs. The Board recently selected a vendor who can provide information about Vermont's current oral health care delivery and financing systems. This analysis will inform system improvement and solutions to reduce barriers and increase access to quality, risk-based and evidence-based care. We expect the analysis to be completed in the fall.

The GMCB is also exploring a broad definition of "benefits" beyond traditionally covered health services. As one part of this effort, the GMCB commissioned an analysis of Vermont's dental-health landscape following extensive discussion of Vermont's dental needs when the Board approved Essential Health Benefits for Vermont Health Connect.

Preliminary findings, presented to the Board in October, offered initial observations on current needs and costs, new ideas proposed in Vermont and other states, and the likely costs and outcomes of any new programs. The preliminary report is available on the Board's web site: http://www.gmcboard.vermont.gov/sites/gmcboard/files/Oral%20Health%20Policy%20Presentation%20GMCB.pdf.

Workforce

In January, the GMCB approved the Administration's Workforce Strategic Plan–which the Administration submitted to the Legislature on January 15. The plan can be found at http://www.leg.state.vt.us/reports/2013ExternalReports/285604.pdf.

Implementing the first recommendation in the plan, the Health Care Workforce Work Group was established by Executive Order on August 1, 2013. Since then, 25 members were appointed, and the Work Group held its first bimonthly meeting in September. The group will focus on current methods of assessing supply and demand of workforce and how those methods can be improved. The Legislature facilitated this work with Act 79 of 2013, which requires licensed professionals to submit data needed for workforce strategic planning to the State as part of the licensing process. The Work Group expects to present the GMCB with revisions to the strategic plan as work moves forward.

Health Information Technology

Over the last several years, Vermont Information Technology Leaders (VITL) the state's designated entity for developing and operating the statewide Vermont Health Information Exchange (VHIE)–has assisted health care providers with adopting and implementing electronic health records (EHR), developing the interfaces necessary to exchange clinical and patient information, and deploying the technology infrastructure to allow providers to obtain clinical data. GMCB Chair Al Gobeille serves on the VITL Board.

The VHCIP has formed a Health Information Exchange/Health Information Technology (HIE/HIT) Work Group. The group has held two meetings, and has created two sub-groups to address specific issues identified by the group. Members include representatives of State government, State HIE representatives, provider and payer representatives, consumers, consultants, and subject matter experts.

Public Engagement

Even before the GMCB had an official office in Montpelier, individual Board members were crisscrossing Vermont to speak with groups all over the state and to see the situation on the ground at local hospitals, mental health agencies, businesses, and schools. In 2013, Board members logged more than 60 speaking engagements all over Vermont and in front of a few key national audiences where the GMCB might find new perspectives and support for Vermont's programs.

This outreach took on a new dimension in 2013, when the full Board began moving some of its weekly meetings out of Montpelier and holding them in communities around Vermont. "Traveling Board Meetings" debuted with stops in Bennington in April, Newport in June, and Rutland in October. The meetings provided the opportunity to hear from health, mental health and home health agencies, hospital administrators, business leaders, and others. Highlights included:

- Discussion of an innovative dental clinic at Molly Stark Elementary School in Bennington.
- Consideration of the current and future health care needs in Newport, given the major economic development in the area.
- Overviews of a brand-new opiate addiction facility and a pilot program for Congestive Heart Failure in Rutland.

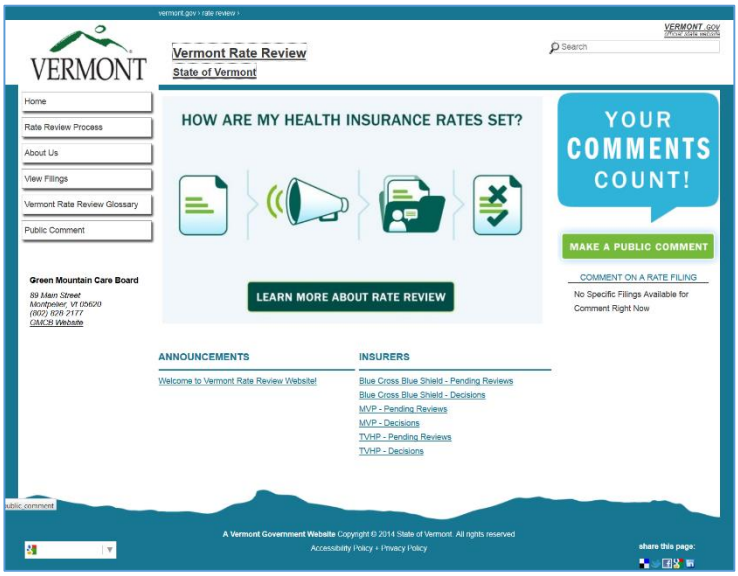
As part of its broad program of public engagement, the GMCB currently has three formal advisory groups:

- The Advisory Committee, which is required by Act 48, met twice in 2013.
- The Health Care Professional Technical Advisory Committee also met twice.
- The Mental Health/Substance Abuse Technical Advisory Committee met three times.

The GMCB is currently planning its advisory groups' 2014 schedules mindful of the fact that a significant portion of GMCB advisory group members have joined Board and staff members in playing major roles in VHCIP leadership and working groups, which already have ambitious 2014 schedules.

The GMCB's family of publications continued to expand in 2013, with the addition of a new edition of the *Green Mountain Guide*, this one providing a general overview of health reform in Vermont and the role of the GMCB. It is available on the web site and in printed form, and will be updated in 2014. Another publication–*The GMCB Progress Report*–was published three times in 2013. Originally intended for the GMCB Advisory Committee and other key stakeholder groups, this publication has been adapted for broader use and given greater prominence on the web site.

The GMCB's web site's evolution continues, with a growing emphasis on the site's use as a conduit for public participation in issues before the Board. This is especially true for the insurance rate review process. Using grant funding, the Department of Financial Regulation and the GMCB collaborated to create a new rate review web site, which debuted January 1, 2014, reflecting changes in the rate review process that went into effect that day.



GMCB Priorities for 2014

The principles of Act 48 call for building a unified health care *system* in Vermont, mindful of the various impacts on individuals and businesses, and both accountable and transparent in operation. As the GMCB's work evolves, integration of the state's fragmented health care landscape into this system is one of our overarching priorities.

This movement toward integration informs many of our 2014 priorities: We have achieved a measure of success with our individual responsibilities, have fit them together where and how we could as we moved forward, and now have the experience and perspective to begin more-assertively putting the pieces together so that Vermonters have the kind of responsible, responsive system that the framers of Act 48 envisioned.

In short, the GMCB believes that we can't succeed in helping health care professionals integrate their work if we don't do the same in our own sphere of responsibility.

Priorities for Regulation

- **Maintain downward pressure on health care costs** through continuously improved review of hospital budgets, capital spending, and insurance rates. This will involve continuing to approach hospitals, insurers and other regulated entities with a stance that is firm and unequivocally clear about expectations and goals of the Board on behalf of the people of Vermont, but is at the same time collaborative and productive for all parties involved.

- **Further integrate regulatory systems** so that each cycle of each regulatory task fits into a broader context. If we are demanding that various components of our health care system find ways to integrate in service to Vermonters, we must do the same: Certificate of Need review must be more closely tied to hospital budget review, which in turn must be more closely tied with health insurance rate review. This must also be true of the outcomes of regulatory processes: The trajectory of hospital budgets and rates must track with the trajectory of insurance rates.

Priorities for Innovation

- **Continue to refine and expand opportunities to test improvements** in health care delivery and payment through pilot projects carried out with a growing network of private-public partnerships that involve representatives of the vast range of stakeholders, including consumers. The Vermont Health Care Innovation Project (VHCIP) will be an important catalyst in this process.

- **Identify and address areas of the system that may not have traditionally received equitable attention and support in payment and delivery reform efforts.** Vermonters' unmet needs for mental health and substance abuse services have moved front and center on the public stage. In 2014, the GMCB intends to dedicate additional time and attention to this piece of our state's fragmented health care system. The experience of learning more about these needs has taught us to be watchful for other parts of the system, such as home health services, that play a significant role in Vermonters' health but are sometimes at the back of the line when it comes to support for health care innovations.

- **Increasingly integrate Public Health Improvement/Total Population Health** strategies in pilot projects and other innovative efforts. To meet the goals of reducing cost, improving quality, and improving health, the GMCB will collaborate with numerous public and private partners to increase our focus on the non-clinical social, economic, and behavioral determinants of health, as well as the inclusion of primary prevention efforts.

Priorities for Evaluation

- **Continue to improve the GMCB's ability to accurately and objectively monitor, evaluate, and report on Vermont's health care system.** The GMCB has been assigned responsibility and authority over powerful tools, including Vermont's all-payer claims dataset, known as the Vermont Health Claims Uniform Reporting and Evaluation System (VHCURES). Through thoughtful evolution of this system and other capacities–including further development of a Vermont Health Dashboard–we will create the conditions necessary for appropriate monitoring, forecasting, and analysis based on solid data.

- **Evaluate and share results of health care innovation efforts.** Improving Vermont's health data systems will help to quickly evaluate and share lessons from the many pilot projects the GMCB is helping its partners conduct around Vermont.

- **Clarify, communicate about, and plan for adequate support of the GMCB's evaluative duties with regard to Green Mountain Care.** Act 48 assigns the GMCB responsibility for evaluation of several key aspects of the Administration's proposals for Green Mountain Care, including its benefits, financing plan, economic impact, sustainability, impact on the health care workforce, and fit with the principles of Act 48. While the evaluative work of these duties will take place beyond 2014, the importance and scope of the duties demand thoughtful preparation and discussion with stakeholders. This work will be of increasing importance in 2014.

Appendices

Appendix A: Statutory Requirements of this Report

Vermont law requires that the GMCB report annually to the Legislature on the following subjects:

- Any changes to the payment rates for health care professionals established by the GMCB.
- Any new developments with respect to health information technology.
- Any health system evaluation criteria adopted by the GMCB.
- Any results of the system-wide performance and quality evaluations required of the GMCB.
- Any recommendations on mechanisms to ensure that appropriations intended to address the Medicaid cost shift will have the intended result of reducing the premiums imposed on commercial insurance premium payers below the amount they otherwise would have been charged.
- Any recommendations for modifications to Vermont statutes.
- Any actual or anticipated impacts on the work of the board as a result of modifications to federal laws, regulations, or programs.

Changes to payment rates for health care professionals established by the GMCB

The GMCB did not make any broad changes to payment rates for health care professionals during 2013.

New developments with respect to health information technology

The GMCB increased its presence in the development of Vermont's health information technology infrastructure and capabilities in 2013. Beginning in December 2012, the Chair of the GMCB assumed a seat on the VITL board. In addition, Act 79 of 2013 gave the Board the authority to review and consider Health Information Exchange (HIE) connectivity as a factor in the hospital budget review process, using criteria established by VITL. *See* 18 V.S.A. § 9456(b)(11) (added by 2013, No. 79, § 34). VITL has begun to develop those criteria, which the Board will discuss in public meetings in the first quarter of 2014. Throughout 2014, the GMCB will seek to ensure that development of the HIE is progressing with necessary speed, and that continued investments by hospitals and other health care providers in electronic health records are well-informed and well-targeted.

Health system evaluation criteria adopted by the GMCB

In keeping with the Act 48 requirement to evaluate the performance of Vermont's health system, the GMCB launched "GMCB Health System Dashboard 1.0"in August, 2012. This first iteration presents easy-to-understand analysis of data on 26 key indicators in four critical areas: cost, access to care, healthy lives, and prevention and treatment. It can be found at: http://www.gmcboard.vermont.gov/dashboardproject. GMCB Dashboard 2.0 will incorporate input and guidance from the GMCB and Dashboard Stakeholder Group in order to accomplish the following:

- Identify dashboard indicators that are accessible to health care consumers.
- Align with measures reported elsewhere and/or use existing data streams.
- Include the most currently available data.
- Align with the goals for the GMCB Dashboard.

Work on GMCB Dashboard 2.0 began in August, 2013 and will conclude in June, 2014.

In addition, as part of the development of payment reform pilot projects, the Board has identified specific measures of quality, patient experience, and cost that will be used to evaluate the pilots. In early 2012, the GMCB formed a broadly representative Accountable Care Organization (ACO) quality measures working group that, over the course of nine months, developed recommendations for quality and performance measures to be used in evaluating ACOs. Through a collaborative process of carefully selecting and discussing each potential measure, the work group recommended Year 1 (2014) payment and reporting measure sets to the Vermont Health Care Innovation Project Steering Committee, Core Team, and the Green Mountain Care Board (GMCB) for final approval. The work group also recommended Year 1 scoring processes. After the receipt of the Federal State Innovation Model Grant, the ACO quality measures working group initiated by the GMCB was broadened further and reconstituted as the Vermont Health Care Innovation Project's Quality and Performance Measures Work Group.

Results of the system-wide performance and quality evaluations required of the GMCB
See the description of the Dashboard above.

Recommendations on mechanisms to ensure that appropriations intended to address the Medicaid cost shift will have the intended result of reducing the premiums imposed on commercial insurance premium payers below the amount they otherwise would have been charged
As detailed in the body of this report, the GMCB held hospitals accountable for basing their budgets on the anticipated impact of the Legislature's additional Medicaid appropriations. The GMCB will continue to monitor the cost shift and the specific impact of Medicaid appropriations. Board and staff members are available to present further details and updates on the cost shift as more data becomes available.

Recommendations for modifications to Vermont statutes
The GMCB does not anticipate requesting any modifications to Vermont statutes during the 2014 legislative session.

Actual or anticipated impacts on the work of the Board as a result of modifications to federal laws, regulations, or programs
The most likely impact of federal policy on the work of the GMCB during 2014 will result from Medicare payment policy. Any cuts in Medicare payments to Vermont health care providers, as are anticipated, will create pressure for providers to cut costs and for the GMCB to allow further shifting of costs to private payers. The cost shift borne by private payers in Vermont already is untenable.

On the other hand, CMS is attempting to support payment innovations, some of which are fully consistent with Vermont's payment reform efforts. CMS has used its innovation arm, The Centers for Medicare and Medicaid Innovation (CMMI), to promote alternatives to fee-for-service payment. CMMI's State Innovation Model (SIM) grant, awarded to Vermont in 2013, supports value-based purchasing, episodes of care or bundled payments, shared savings or population based payments, and the dual-eligible demonstration. Using SIM funds, Vermont will leverage the Vermont Health Care Innovation Project (VHCIP) to complement and accelerate efforts to change provider payment.

Finally, any changes in–or further definition of–the federal regulations that govern Essential Health Benefits on Vermont's Health Benefit Exchange could impact our work in that arena.

Appendix B: Alignment with the Principles of Act 48

Act 48 Principle	GMCB Work Aligned with this Principle
(1) The state of Vermont must ensure universal access to and coverage for high-quality, medically necessary health services for all Vermonters. Systemic barriers, such as cost, must not prevent people from accessing necessary health care. All Vermonters must receive affordable and appropriate health care at the appropriate time in the appropriate setting.	Much of our work during 2013 was aligned with this principle, including payment reform, hospitals budgeting, benefits standards for Vermont Health Connect and health insurer rate reviews.
(2) Overall health care costs must be contained and growth in health care spending in Vermont must balance the health care needs of the population with the ability to pay for such care.	Much of our work during 2013 was aligned with this principle, including payment reform, hospital budgeting and health insurer rate reviews.
(3) The health care system must be transparent in design, efficient in operation, and accountable to the people it serves. The state must ensure public participation in the design, implementation, evaluation, and accountability mechanisms of the health care system.	The body of this report describes much work to improve transparency and accountability through the GMCB. This includes open weekly Board meetings (including traveling meetings in Bennington, Newport, and Rutland), a new rate review web site, meetings with advisory committees, explanatory publications for consumers, and more than 60 public events at which GMCB members and their staff explained the Board's work.
(4) Primary care must be preserved and enhanced so that Vermonters have care available to them, preferably within their own communities. Other aspects of Vermont's health care infrastructure, including the educational and research missions of the state's academic medical center and other postsecondary educational institutions, the nonprofit missions of the community hospitals, and the critical access designation of rural hospitals, must be supported in such a way that all Vermonters, including those in rural areas, have access to necessary health services and that these health services are sustainable.	Enhancement of primary care has been a specific focus of the GMCB's payment and delivery reform policy. Investments in strengthening primary care were considered a legitimate exemption from hospital budget constraints. As discussed in the body of this report, it is central to the GMCB's role to consider the full scope of needs in Vermonter's health care infrastructure. This includes the unique needs of the state's rural areas and the role of the state's academic medical center.

(5) Every Vermonter should be able to choose his or her health care providers.	The GMCB's regulatory and innovation efforts preserve Vermonters' freedom to choose their health care providers.
(6) Vermonters should be aware of the costs of the health services they receive. Costs should be transparent and easy to understand.	Cost is a major focus of virtually all of the GMCB's regulatory and innovation activities. For example, the GMCB publishes the annual Expenditure Analysis, a key source of information for government, consumers, and regulated entities regarding health care costs. In 2014, we will explore the feasibility of using VHCURES, the state's all-payer claims database, as a means to provide cost information to Vermonters.
(7) Individuals have a personal responsibility to maintain their own health and to use health resources wisely, and all individuals should have a financial stake in the health services they receive.	The GMCB has commissioned ongoing consulting work to understand how health determinants such as the environment, personal behavior and socio-economic status affect health care costs and outcomes. We continue to look for ways to incorporate this knowledge in our policy and regulatory decisions.
(8) The health care system must recognize the primacy of the relationship between patients and their health care practitioners, respecting the professional judgment of health care practitioners and the informed decisions of patients.	Where appropriate, our policy decisions around payment and delivery reform aim to incorporate both best practices identified by health care practitioners and shared patient/provider decision-making.
(9) Vermont's health delivery system must seek continuous improvement of health care quality and safety and of the health of the population and promote healthy lifestyles. The system therefore must be evaluated regularly for improvements in access, quality, and cost containment.	Development of data systems and analytic capacity to support evaluation of health reform is a major, ever-present priority for the GMCB. For example, with the data warehousing contract for VHCURES expiring in August 2014, the GMCB has already begun working with stakeholders inside and outside of state government to design a secure, comprehensive solution for the next phase of VHCURES.
(10) Vermont's health care system must include mechanisms for containing all system costs and eliminating unnecessary expenditures, including by reducing administrative costs and by reducing costs that do not contribute to efficient, high-quality health services or improve health outcomes. Efforts to reduce overall health care costs should identify sources of excess cost growth.	Identifying drivers of health care cost growth, and areas in which our system can be more efficient, are central to our payment reform and cost control efforts.

(11) The financing of health care in Vermont must be sufficient, fair, predictable, transparent, sustainable, and shared equitably.	The balance between provider solvency, sustainable cost control, and the equitable sharing of costs among Vermonters has been at the heart of the GMCB's efforts to establish reasonable hospital budgets and insurer rates. The Board is also beginning to consider and plan for its statutory duties to evaluate the proposed Green Mountain Care system before it is implemented.
(12) The system must consider the effects of payment reform on individuals and on health care professionals and suppliers. It must enable health care professionals to provide, on a solvent basis, effective and efficient health services that are in the public interest.	In addition to the work described above, part of the Board's evaluative role relative to Green Mountain Care is to determine whether a proposed public-private universal health care system will allow for sufficient provider reimbursement to enable the recruitment and retention of high-quality providers.
(13) Vermont's health care system must operate as a partnership between consumers, employers, health care professionals, hospitals, and the state and federal government.	The GMCB has brought numerous constituencies into our decision-making processes through public meetings, targeted outreach and general public education. In addition, working across state agencies to achieve alignment of our policies has been a major focus. This cross- and inter-disciplinary approach is part of the fabric of our work and will continue, if not intensify, going forward.
(14) State government must ensure that the health care system satisfies the principles expressed in this section.	As described above and throughout this report, the Board brings these principles to bear on its work. Indeed, these principles are woven into the Board's specific statutory duties and authorities, and they guide our regulatory and policy decision-making.

Appendix C: List of 2013 GMCB Meetings

Meeting Date	Topics
1/3/13	Workforce Strategic Plan presentation by Robin Lunge, Director of Health Care Reform, David Reynolds, Deputy Commissioner of Health Care Administration, Department of Financial Regulation, and Craig Stevens, JSI Research and Training Institute
1/09/13	The Board discussed Health Care Expenditure Targets and the Workforce Strategic Plan
1/17/13	Report on health care costs related to undocumented immigrants by Michael Donofrio, GMCB General Counsel Update on Payment Reform by Richard Slusky, Director of Payment Reform
1/23/13	The Board discussed Health Care Expenditure Targets
1/31/13	Primary Care Service Areas Spatial Analysis by Dian Kahn, Department of Financial Regulation, and David Healy, Stone Environmental Inc.
2/07/13	Presentation on Vermont Information Technology Leaders by John K. Evans, President/CEO of VITL Proposal for legislative changes to major medical health insurance rate process by Michael Donofrio, General Counsel Discussion of Health Care Expenditure Target Presentation on OneCare Vermont by Todd Moore, CEO, OneCare Vermont
2/21/13	Discussion of a Health Care Expenditure Target Presentation on Vermont Program for Health Care Quality Annual Report by Catherine Fulton, Executive Director, VPQHC Rate Review Process and Supplemental Forms Presentation by Judith Henkin, Health Policy Director Public Engagement Briefing by Rick Blount Payment Reform: OneCare Pilot Application Discussion
2/28/13	Health Expenditure Analysis FY 2011 Discussion
3/7/13	Essential Health Benefits for exchange plans presentation by Lindsey Tucker, Deputy Commissioner for the Health Benefit Exchange, and Julie Peper, Wakely Consulting Hospital Conversion Statute discussion by Michael Donofrio, General Counsel Payment Reform update by Richard Slusky, Director of Payment Reform 2012 Vermont Household Health Insurance Survey presentation by Sarah Lindberg, Department of Financial Regulation
3/13/13	Discussion of Essential Health Benefits for exchange plans
3/21/13	Porter Medical Center presentation by Jim Daily, President/CEO Certificate of Need Update By Donna Jerry, Health Policy Analyst, and Judith Henkin, Health Policy Director Fletcher Allen Health Care: Discussion of Upcoming Certificates of Need by Roger Deshaies, CFO, and Spencer Knapp, Sr., VP and General Counsel

Meeting Date	Topics
4/4/13	Rate Review: Health Benefit Exchange 2014 Filings presentation by Judith Henkin, Health Policy Director Discussion of H. 440: Open meeting law; hospitals by Michael Donofrio, General Counsel, Bea Grause, VAHHS, and Ellen Oxfeld, Vermont Health Care For All Payment Reform update by Richard Slusky, Director of Payment Reform
4/8/13	Traveling Board Meeting: Bennington Update on Rate Review & Certificate of Need Process by Judith Henkin, Director of Health Policy The Vermont Blueprint For Health's Bennington area activities update by Dana Noble, RN, MBA, Blueprint Project Manager and Gregory King, M.D., Mount Anthony Primary Care Update from Southwestern Vermont Health Care by Thomas Dee, CEO Molly Start Elementary School Dental Clinic presentation by Michael Brady, DDS
4/11/13	Certificate of Need: Crescent Manor Application presentation by Judith Henkin, Health Policy Director Hospital Budgets Discussion by Mike Davis, Director of Health System Finances
4/25/13	Support and Services at Home (SASH) Update by Nancy Eldridge, Executive Director, Cathedral Square Certificate of Need discussion by Donna Jerry, Health Care Administrator
5/02/13	FY14 Hospital Budget Process Discussion by Mike Davis, Director of Health System Finances
5/09/13	Health Benefits Exchange Update by Lindsey Tucker, Deputy Commissioner for the Health Benefit Exchange, Department of Vermont Health Access
5/23/13	Healthy Vermont 2020 discussion by Tracy Dolan, Deputy Commissioner for Public Health, Vermont Department of Health
5/30/13	Phase 1 Variation Analysis Report by Michael Del Trecco, Vice President of Finance, Vermont Association of Hospitals and Health Systems
6/06/13	Briefing on 2013 Legislation Affecting the GMCB by Michael Donofrio, General Counsel, and Georgia Maheras, Executive Director Payment Reform Update: Brattleboro Memorial Hospital and Grace Cottage by Richard Slusky, Director of Payment Reform
6/13/13	Traveling Board Meeting: Newport Insurance rate review process update by Judith Henkin, GMCB Health Policy Director, and Michael Donofrio, General Counsel Anticipated development and population changes in the Northeast Kingdom by Bill Stenger, President & CEO, Jay Peak A view from the hospital and health system by Claudio Fort, President & CEO, North Country Hospital, and Kathryn Austin, Chair of the Board, North Country Hospital A view from the front lines of human services by Erik Grims, Executive Director, Northeast Kingdom Human Services A view from the front lines of primary care by Robert Primeau, MD, physician at Northern Counties Health Care & President of Medical Staff, North Country Hospital
6/20/13	Briefing on Hospital Budget Financial Software by Mike Davis, Director of Health System Finances, and Ethan Carlson, Carlson Management Consulting

Meeting Date	Topics
	Discussion of FY13 Hospital Budget Adjustment(s) by Mike Davis, Director of Health System Finances Payment Reform Update by Richard Slusky, Director of Payment Reform
7/25/13	Fiscal Year 2014 Hospital Budget Discussion by Mike Davis, Director of Health System Finances Draft Rate Review Rule Presentation by Michael Donofrio, General Counsel
8/08/13	Payment Reform Pilot Update by Richard Slusky, GMCB Director of Payment Reform Certificate of Need for Fletcher Allen Health Care by Judith Henkin, GMCB Health Policy Director
8/27/13	Hospital Budget Hearings
8/28/13	Hospital Budget Hearings
8/29/13	Hospital Budget Hearings
9/10/13	Hospital Budget Discussion
9/11/13	Fletcher Allen Health Care Budget Presentation Hospital Budget Discussion
9/16/13	Discussion of Fletcher Allen Health Care's Budget Hospital Budget Process Discussion by Michael Donofrio, General Counsel
9/26/13	Fletcher Allen Health Care - Certificate of Need Hearing Gifford Medical Center - Certificate of Need Hearing ACO Standards discussion by Richard Slusky, GMCB Director of Payment Reform
10/03/13	Home Health Services in Vermont presentation by Peter Cobb, Executive Director, Vermont Assembly of Home Health Agencies Head CT Scan Update by Cyrus Jordan, MD, Vermont Medical Society, and Steve Kappel, Policy Integrity
10/10/13	Workforce Strategic Plan Update by David Reynolds, Deputy Director of Health Care Reform – Policy, Agency of Administration, and Mary Val Palumbo, Co-Chair, Health Care Workforce Work Group Vote on Certificate of Need: Fletcher Allen Health Care – Mother Baby Unit Vote on Certificate of Need: Gifford Medical Center – Skilled Nursing Facility VHCURES Update by Michael Donofrio, General Counsel, and Dian Kahn, Director of Analysis and Data Management Payment Reform Update by Richard Slusky, Director of Payment Reform, and Pat Jones, Health Care Project Director
10/17/13	Traveling Board Meeting: Rutland Congestive Heart Failure Pilot & other issues in the Rutland community presentation by Thomas Huebner, President of Rutland Regional Medical Center Opioid addiction treatment & substance abuse in the Rutland Community presentation by Jeffrey McKee, Psy.D., Director of Psychiatric Services at RRMC, and Jessi Farnsworth, LADC, LCMHC, Program Director, West Ridge Center for Addiction Recovery Mental health issues in the Rutland Community presentation by Dan Quinn, M.S.W., M.B.A., President & CEO, Rutland Mental Health Services Home health and hospice issues in the Rutland area presentation by Ron Cioffi, R.N., Executive Director of the Rutland Area Visiting Nurse Association

Meeting Date	Topics
10/24/13	Dental Project Update by Craig Stevens, JSI Research and Training Institute Hospital Budget Adjustments presentation by Mike Davis, Director of Health System Finances CON and Rate Review Update by Judith Henkin, Esq., Health Policy Director Rate Review Rule Update by Michael Donofrio, Esq., General Counsel
11/07/13	Integrated Family Services in the Agency of Human Services by Melissa Bailey, MA, LCMHC, AHS Director of Integrated Family Services Hospital Budget Adjustments presentation by Mike Davis, Director of Health System Finances
11/14/13	Health Care Cost Institute Collaborative Benchmarking Project Update by Dian Kahn, Director of Analysis and Data Management, and Carolina-Nicole S. Herrera, Health Care Cost Institute Director of Research Vermont Collaborative Care presentation by Kevin Goddard, BCBS Vice President of External Affairs and Sales, Robert Wheeler, BCBS Chief Medical Officer, and Peter Albert, Brattleboro Retreat Vice President
11/21/13	Rethink Health presentation by Steve Voigt, CEO of King Arthur Flour Company, Inc., and Elliott Fisher, MD, MPH, Director at The Dartmouth Institute for Health Policy and Clinical Practice CON and Rate Review Update by Judith Henkin, Health Policy Director Expenditure Analysis Update by Mike Davis, Director of Health System Finances BCBSVT VHCURES Application and Vote by Dian Kahn, Director of Analysis and Data Management ACO Standards and Measures Presentation and Vote by Ena Backus, Health Care Reform Specialist; Spenser Weppler, Health Care Reform Specialist Vote on SIM Evaluation RFP
12/05/13	Hospitalist White Paper presentation by Cy Jordan, MD, Vermont Medical Society Education & Research Foundation Vote on ACO Measures and Standards Executive Session to discuss the RFP for Actuarial Services for Major Medical Insurance Rate Review Vote on the RFP for Actuarial Services for Major Medical Insurance Rate Review
12/12/13	Rural Communities White Paper presentation by Cy Jordan, MD, Vermont Medical Society Education & Research Foundation Truven Analytics presentation by Mike Davis, Director of Health System Finances, William D. Marder, PhD, Senior Vice President, Truven Health Analytics, and Cindy Parks Thomas PhD, Associate Research Professor, Brandeis University
12/19/13	Director's Report by Mike Davis , Director of Health System Finances Global Budgets in Vermont presentation by Bob Murray, Global Health Payment, LLC VITL Connectivity Criteria presentation by John Evans, CEO, VITL, and Liora Alschuler, CEO, Lantana Consulting Group Executive Session to discuss the Project Management Proposal Related to the VHCURES RFP - presentation by Stacey Murdock, Data and Information Project Manager Vote on the Project Management Proposal Related to the VHCURES RFP

Appendix D: Full listing of GMCB Powers & Authorities

The Vermont Legislature established the Green Mountain Care Board and delegated powers and duties to it in Act 48 of 2011. Most of the statutes defining the Board and its roles appear at sections 9371-9381 of Title 18 of Vermont Statutes Annotated. The specific sections containing the Board's powers and duties are reproduced in full below. Section 1822 of Title 33, which sets out the determinations the Board must make before Green Mountain Care can be implemented, is also reproduced in full below.

As set forth in 18 V.S.A. § 9375(b) (6)-(8) (see below), the Board has jurisdiction over health insurance rate review, hospital budget review, and certificate of need review. The specific statutes governing those review processes are not reproduced in this Appendix, and can be found in Vermont Statutes Annotated as follows:
Health insurance rate review: 8 V.S.A. § 4062
Hospital budget review: 18 V.S.A. §§ 9453-9457
Certificate of need review: 18 V.S.A. §§ 9431-9446

18 V.S.A. § 9372. Purpose

It is the intent of the general assembly to create an independent board to promote the general good of the state by:

(1) improving the health of the population;

(2) reducing the per-capita rate of growth in expenditures for health services in Vermont across all payers while ensuring that access to care and quality of care are not compromised;

(3) enhancing the patient and health care professional experience of care;

(4) recruiting and retaining high-quality health care professionals; and

(5) achieving administrative simplification in health care financing and delivery.

18 V.S.A. § 9374. Board membership; authority

(a)(1) On July 1, 2011, the Green Mountain Care board is created and shall consist of a chair and four members. The chair and all of the members shall be state employees and shall be exempt from the state classified system. The chair shall receive compensation equal to that of a superior judge, and the compensation for the remaining members shall be two-thirds of the amount received by the chair.

(2) The chair and the members of the board shall be nominated by the Green Mountain Care board nominating committee established in subchapter 2 of this chapter using the qualifications described in section 9392 of this chapter and shall be otherwise appointed and confirmed in the manner of a superior judge. The governor shall not appoint a nominee who was denied confirmation by the senate within the past six years.

(b)(1) The initial term of the chair shall be seven years, and the term of the chair shall be six years thereafter.

(2) The term of each member other than the chair shall be six years, except that of the members first appointed, one each shall serve a term of three years, four years, five years, and six years.

(3) Subject to the nomination and appointment process, a member may serve more than one term.

(4) Members of the board may be removed only for cause. The board shall adopt rules pursuant to 3 V.S.A. chapter 25 to define the basis and process for removal.

(c)(1) No board member shall, during his or her term or terms on the board, be an officer of, director of, organizer of, employee of, consultant to, or attorney for any person subject to supervision or regulation by the board; provided that for a health care practitioner, the employment restriction in this

subdivision shall apply only to administrative or managerial employment or affiliation with a hospital or other health care facility, as defined in section 9432 of this title, and shall not be construed to limit generally the ability of the health care practitioner to practice his or her profession.

(2) No board member shall participate in creating or applying any law, rule, or policy or in making any other determination if the board member, individually or as a fiduciary, or the board member's spouse, parent, or child wherever residing or any other member of the board member's family residing in his or her household has an economic interest in the matter before the board or has any more than a de minimus interest that could be substantially affected by the proceeding.

(3) The prohibitions contained in subdivisions (1) and (2) of this subsection shall not be construed to prohibit a board member from, or require a board member to recuse himself or herself from board activities as a result of, any of the following:

(A) being an insurance policyholder or from receiving health services on the same terms as are available to the public generally;

(B) owning a stock, bond, or other security in an entity subject to supervision or regulation by the board that is purchased by or through a mutual fund, blind trust, or other mechanism where a person other than the board member chooses the stock, bond, or security; or

(C) receiving retirement benefits through a defined benefit plan from an entity subject to supervision or regulation by the board.

(4) No board member shall, during his or her term or terms on the board, solicit, engage in negotiations for, or otherwise discuss future employment or a future business relationship of any kind with any person subject to supervision or regulation by the board.

(5) No board member may appear before the board or any other state agency on behalf of a person subject to supervision or regulation by the board for a period of one year following his or her last day as a member of the Green Mountain Care board.

(d) The chair shall have general charge of the offices and employees of the board but may hire a director to oversee the administration and operation.

(e)(1) The board shall establish a consumer, patient, business, and health care professional advisory group to provide input and recommendations to the board. Members of such advisory group who are not state employees or whose participation is not supported through their employment or association shall receive per diem compensation and reimbursement of expenses pursuant to 32 V.S.A. § 1010, provided that the total amount expended for such compensation shall not exceed $5,000.00 per year.

(2) The board may establish additional advisory groups and subcommittees as needed to carry out its duties. The board shall appoint diverse health care professionals to the additional advisory groups and subcommittees as appropriate.

(f) In carrying out its duties pursuant to this chapter, the board shall seek the advice of the state health care ombudsman established in 8 V.S.A. § 4089w. The state health care ombudsman shall advise the board regarding the policies, procedures, and rules established pursuant to this chapter. The ombudsman shall represent the interests of Vermont patients and Vermont consumers of health insurance and may suggest policies, procedures, or rules to the board in order to protect patients' and consumers' interests.

(g) The chair of the board or designee may apply for grant funding, if available, to advance or support any responsibility within the board's jurisdiction.

(h)(1) Expenses incurred to obtain information, analyze expenditures, review hospital budgets, and for any other contracts authorized by the board shall be borne as follows:

(A) 40 percent by the state from state monies;

(B) 15 percent by the hospitals;

(C) 15 percent by nonprofit hospital and medical service corporations licensed under 8 V.S.A. chapter 123 or 125;

(D) 15 percent by health insurance companies licensed under 8 V.S.A. chapter 101; and

(E) 15 percent by health maintenance organizations licensed under 8 V.S.A. chapter 139.

(2) Expenses under subdivision (1) of this subsection shall be billed to persons licensed under Title 8 based on premiums paid for health care coverage, which for the purposes of this section shall include major medical, comprehensive medical, hospital or surgical coverage, and comprehensive health care services plans, but shall not include long-term care or limited benefits, disability, credit or stop loss, or excess loss insurance coverage.

(i) In addition to any other penalties and in order to enforce the provisions of this chapter and empower the board to perform its duties, the chair of the board may issue subpoenas, examine persons, administer oaths, and require production of papers and records. Any subpoena or notice to produce may be served by registered or certified mail or in person by an agent of the chair. Service by registered or certified mail shall be effective three business days after mailing. Any subpoena or notice to produce shall provide at least six business days' time from service within which to comply, except that the chair may shorten the time for compliance for good cause shown. Any subpoena or notice to produce sent by registered or certified mail, postage prepaid, shall constitute service on the person to whom it is addressed. Each witness who appears before the chair under subpoena shall receive a fee and mileage as provided for witnesses in civil cases in superior courts; provided, however,
any person subject to the board's authority shall not be eligible to receive fees or mileage under this section.

(j) A person who fails or refuses to appear, to testify, or to produce papers or records for examination before the chair upon properly being ordered to do so may be assessed an administrative penalty by the chair of not more than $2,000.00 for each day of noncompliance and proceeded against as provided in the Administrative Procedure Act, and the chair may recommend to the appropriate licensing entity that the person's authority to do business be suspended for up to six months.

18 V.S.A. § 9375. Duties

(a) The board shall execute its duties consistent with the principles expressed in 18 V.S.A. § 9371.

(b) The board shall have the following duties:

(1) Oversee the development and implementation, and evaluate the effectiveness, of health care payment and delivery system reforms designed to control the rate of growth in health care costs and maintain health care quality in Vermont, including ensuring that the payment reform pilot projects set forth in this chapter are consistent with such reforms.

(A) Implement by rule, pursuant to 3 V.S.A. chapter 25, methodologies for achieving payment reform and containing costs, which may include the creation of health care professional cost-containment targets, global payments, bundled payments, global budgets, risk-adjusted capitated payments, or other uniform payment methods and amounts for integrated delivery systems, health care professionals, or other provider arrangements.

(B) Prior to the initial adoption of the rules described in subdivision (A) of this subdivision (1), report the board's proposed methodologies to the house committee on health care and the senate committee on health and welfare.

(C) In developing methodologies pursuant to subdivision (A) of this subdivision (1), engage Vermonters in seeking ways to equitably distribute health services while acknowledging the connection between fair and sustainable payment and access to health care.

(D) Nothing in this subdivision (1) shall be construed to limit the authority of other agencies or departments of state government to engage in additional cost-containment activities to the extent permitted by state and federal law.

(2) Review and approve Vermont's statewide health information technology plan pursuant to section 9351 of this title to ensure that the necessary infrastructure is in place to enable the state to

achieve the principles expressed in section 9371 of this title.

(3) Review and approve the health care workforce development strategic plan created in chapter 222 of this title.

(4) Review the health resource allocation plan created in chapter 221 of this title.

(5) Set rates for health care professionals pursuant to section 9376 of this title, to be implemented over time, and make adjustments to the rules on reimbursement methodologies as needed.

(6) Approve, modify, or disapprove requests for health insurance rates pursuant to 8 V.S.A. § 4062 within 30 days of receipt of a request for approval from the commissioner of financial regulation, taking into consideration the requirements in the underlying statutes, changes in health care delivery, changes in payment methods and amounts, and other issues at the discretion of the board;

(7) Review and establish hospital budgets pursuant to chapter 221, subchapter 7 of this title, beginning July 1, 2012.

(8) Review and approve, approve with conditions, or deny applications for certificates of need pursuant to chapter 221, subchapter 5 of this title, beginning January 1, 2013.

(9) Prior to the adoption of rules, review and approve, with recommendations from the commissioner of Vermont health access, the benefit package or packages for qualified health benefit plans pursuant to 33 V.S.A. chapter 18, subchapter 1 no later than January 1, 2013. The board shall report to the house committee on health care and the senate committee on health and welfare within 15 days following its approval of the initial benefit package and any subsequent substantive changes to the benefit package.

(10) Develop and maintain a method for evaluating system-wide performance and quality, including identification of the appropriate process and outcome measures:

(A) for determining public and health care professional satisfaction with the health system;

(B) for utilization of health services;

(C) in consultation with the department of health and the director of the Blueprint for Health, for quality of health services and the effectiveness of prevention and health promotion programs;

(D) for cost-containment and limiting the growth in health care expenditures;

(E) for determining the adequacy of the supply and distribution of health care resources in this state;

(F) to address access to and quality of mental health and substance abuse services; and

(G) for other measures as determined by the board.

(11) Develop the unified health care budget pursuant to section 9375a of this title.

(12) Review data regarding mental health and substance abuse treatment reported to the department of financial regulation pursuant to 8 V.S.A. § 4089b(g)(1)(G) and discuss such information, as appropriate, with the mental health technical advisory group established pursuant to subdivision 9374(e)(2) of this title.

(c) The board shall have the following duties related to Green Mountain Care:

(1) Prior to implementing Green Mountain Care, consider recommendations from the agency of human services, and define the Green Mountain Care benefit package within the parameters established in 33 V.S.A. chapter 18, subchapter 2, to be adopted by the agency by rule.

(2) When providing its recommendations for the benefit package pursuant to subdivision (1) of this subsection, the agency of human services shall present a report on the benefit package proposal to the house committee on health care and the senate committee on health and welfare. The report shall describe the covered services to be included in the Green Mountain Care benefit package and any cost-sharing requirements. If the general assembly is not in session at the time that the agency makes its recommendations, the agency shall send its report electronically or by first class mail to each member of

the house committee on health care and the senate committee on health and welfare.
(3) Prior to implementing Green Mountain Care and annually after implementation, recommend to the general assembly and the governor a three-year Green Mountain Care budget pursuant to 32 V.S.A. chapter 5, to be adjusted annually in response to realized revenues and expenditures, that reflects any modifications to the benefit package and includes recommended appropriations, revenue estimates, and necessary modifications to tax rates and other assessments.

18 V.S.A. § 9375a. Expenditure analysis; unified health care budget

(a) Annually, the board shall develop a unified health care budget and develop an expenditure analysis to promote the policies set forth in sections 9371 and 9372 of this title.

(1) The budget shall:

(A) Serve as a guideline within which health care costs are controlled, resources directed, and quality and access assured.

(B) Identify the total amount of money that has been and is projected to be expended annually for all health care services provided by health care facilities and providers in Vermont and for all health care services provided to residents of this state.

(C) Identify any inconsistencies with the state health plan and the health resource allocation plan.

(D) Analyze health care costs and the impact of the budget on those who receive, provide, and pay for health care services.

(2) The board shall enter into discussions with health care facilities and with health care provider bargaining groups created under section 9409 of this title concerning matters related to the unified health care budget.

(b)(1) Annually the board shall prepare a three-year projection of health care expenditures made on behalf of Vermont residents, based on the format of the health care budget and expenditure analysis adopted by the board under this section, projecting expenditures in broad sectors such as hospital, physician, home health, or pharmacy. The projection shall include estimates for:

(A) expenditures for the health plans of any hospital and medical service corporation, health maintenance organization, Medicaid program, or other health plan regulated by this state which covers more than five percent of the state population; and

(B) expenditures for Medicare, all self-insured employers, and all other health insurance.

(2) Each health plan payer identified under subdivision (1)(A) of this subsection may comment on the board's proposed projections, including comments concerning whether the plan agrees with the proposed projection, alternative projections developed by the plan, and a description of what mechanisms, if any, the plan has identified to reduce its health care expenditures. Comments may also include a comparison of the plan's actual expenditures with the applicable projections for the prior year and an evaluation of the efficacy of any cost containment efforts the plan has made.

(3) The board's projections prepared under this subsection shall be used as a tool in the evaluation of health insurance rate and trend filings with the department of financial regulation, and shall be made available in connection with the hospital budget review process under subchapter 7 of this chapter, the certificate of need process under subchapter 5 of this chapter, and the development of the health resource allocation plan.

(4) The board shall prepare a report of the final projections made under this subsection and file the report with the general assembly on or before January 15 of each year.

18 V.S.A. § 9376. Payment amounts; methods

(a) It is the intent of the general assembly to ensure payments to health care professionals that are consistent with efficiency, economy, and quality of care and will permit them to provide, on a solvent

basis, effective and efficient health services that are in the public interest. It is also the intent of the general assembly to eliminate the shift of costs between the payers of health services to ensure that the amount paid to health care professionals is sufficient to enlist enough providers to ensure that health services are available to all Vermonters and are distributed equitably.

(b)(1) The board shall set reasonable rates for health care professionals, health care provider bargaining groups created pursuant to section 9409 of this title, manufacturers of prescribed products, medical supply companies, and other companies providing health services or health supplies based on methodologies pursuant to section 9375 of this title, in order to have a consistent reimbursement amount accepted by these persons. In its discretion, the board may implement rate-setting for different groups of health care professionals over time and need not set rates for all types of health care professionals. In establishing rates, the board may consider legitimate differences in costs among health care professionals, such as the cost of providing a specific necessary service or services that may not be available elsewhere in the state, and the need for health care professionals in particular areas of the state, particularly in underserved geographic or practice shortage areas.

(2) Nothing in this subsection shall be construed to limit the ability of a health care professional to accept less than the rate established in subdivision (1) of this subsection from a patient without health insurance or other coverage for the service or services received.

(c) The board shall approve payment methodologies that encourage cost-containment; provision of high-quality, evidence-based health services in an integrated setting; patient self-management; access to primary care health services for underserved individuals, populations, and areas; and healthy lifestyles. Such methodologies shall be consistent with payment reform and with evidence-based practices, and may include fee-for-service payments if the board determines such payments to be appropriate.

(d) To the extent required to avoid federal antitrust violations and in furtherance of the policy identified in subsection (a) of this section, the board shall facilitate and supervise the participation of health care professionals and health care provider bargaining groups in the process described in subsection (b) of this section.

18 V.S.A. § 9377. Payment reform; pilots

(a) It is the intent of the general assembly to achieve the principles stated in section 9371 of this title. In order to achieve this goal and to ensure the success of health care reform, it is the intent of the general assembly that payment reform be implemented and that payment reform be carried out as described in this section. It is also the intent of the general assembly to ensure sufficient state involvement and action in the design and implementation of the payment reform pilot projects described in this section to comply with federal and state antitrust provisions by replacing competition between payers and others with state-supervised cooperation and regulation.

(b)(1) The board shall be responsible for payment and delivery system reform, including the pilot projects established in this section.

(2) Payment reform pilot projects shall be developed and implemented to manage the costs of the health care delivery system, improve health outcomes for Vermonters, provide a positive health care experience for patients and health care professionals, and further the following objectives:

(A) payment reform pilot projects should align with the Blueprint for Health strategic plan and the statewide health information technology plan;

(B) health care professionals should coordinate patient care through a local entity or organization facilitating this coordination or another structure which results in the coordination of patient care and a sustained focus on disease prevention and promotion of wellness that includes individuals, employers, and communities;

(C) health insurers, Medicaid, Medicare, and all other payers should reimburse health care professionals for coordinating patient care through consistent payment methodologies, which may include a global budget; a system of cost containment limits, health outcome measures, and patient consumer satisfaction targets which may include risk-sharing or other incentives designed to reduce costs while maintaining or improving health outcomes and patient consumer satisfaction; or another payment method providing an incentive to coordinate care and control cost growth;

(D) the scope of services in any capitated payment should be broad and comprehensive, including prescription drugs, diagnostic services, acute and sub-acute home health services, services received in a hospital, mental health and substance abuse services, and services from a licensed health care practitioner; and

(E) health insurers, Medicaid, Medicare, and all other payers should reimburse health care professionals for providing the full spectrum of evidence-based health services.

(3) In addition to the objectives identified in subdivision (a)(2) of this section, the design and implementation of payment reform pilot projects may consider:

(A) alignment with the requirements of federal law to ensure the full participation of Medicare in multipayer payment reform; and

(B) with input from long-term care providers, the inclusion of home health services and long-term care services as part of capitated payments.

(c) To the extent required to avoid federal antitrust violations, the board shall facilitate and supervise the participation of health care professionals, health care facilities, and insurers in the planning and implementation of the payment reform pilot projects, including by creating a shared incentive pool if appropriate. The board shall ensure that the process and implementation include sufficient state supervision over these entities to comply with federal antitrust provisions and shall refer to the attorney general for appropriate action the activities of any individual or entity that the board determines, after notice and an opportunity to be heard, violate state or federal antitrust laws without a countervailing benefit of improving patient care, improving access to health care, increasing efficiency, or reducing costs by modifying payment methods.

(d) The board or designee shall apply for grant funding, if available, for the evaluation of the pilot projects described in this section.

(e) The board or designee shall convene a broad-based group of stakeholders, including health care professionals who provide health services, health insurers, professional organizations, community and nonprofit groups, consumers, businesses, school districts, the state health care ombudsman, and state and local governments, to advise the board in developing and implementing the pilot projects and to advise the Green Mountain Care board in setting overall policy goals.

(f) The first pilot project shall become operational no later than July 1, 2012, and two or more additional pilot projects shall become operational no later than October 1, 2012.

(g)(1) Health insurers shall participate in the development of the payment reform strategic plan for the pilot projects and in the implementation of the pilot projects, including providing incentives, fees, or payment methods, as required in this section. This requirement may be enforced by the department of financial regulation to the same extent as the requirement to participate in the Blueprint for Health pursuant to 8 V.S.A. § 4088h.

(2) The board may establish procedures to exempt or limit the participation of health insurers offering a stand-alone dental plan or specific disease or other limited-benefit coverage or participation by insurers with a minimal number of covered lives as defined by the board, in consultation with the commissioner of financial regulation. Health insurers shall be exempt from participation if the insurer offers only benefit plans which are paid directly to the individual insured or the insured's assigned beneficiaries and for which the amount of the benefit is not based upon potential medical costs or actual costs incurred.

(3) In the event that the secretary of human services is denied permission from the Centers for Medicare and Medicaid Services to include financial participation by Medicare in the pilot projects, health insurers shall not be required to cover the costs associated with individuals covered by Medicare.

(4) After implementation of the pilot projects described in this subchapter, health insurers shall have appeal rights pursuant to section 9381 of this title.

18 V.S.A. § 9377a. Prior authorization pilot program

(a) The Green Mountain Care Board shall develop and implement a pilot program or programs for the purpose of measuring the change in system costs within primary care associated with eliminating prior authorization requirements for imaging, medical procedures, prescription drugs, and home care. The program shall be designed to measure the effects of eliminating prior authorizations on provider satisfaction and on the number of requests for and expenditures on imaging, medical procedures, prescription drugs, and home care. In developing the pilot program proposal, the board shall collaborate with health care professionals and health insurers throughout the State or regionally.

(b) The board shall submit an update regarding implementation of prior authorization pilot programs as part of its annual report under subsection 9375(d) of this title.

33 V.S.A. § 1822. Implementation; waiver

(a) Green Mountain Care shall be implemented 90 days following the last to occur of:

(1) Receipt of a waiver under Section 1332 of the Affordable Care Act pursuant to subsection (b) of this section.

(2) Enactment of a law establishing the financing for Green Mountain Care.

(3) Approval by the Green Mountain Care Board of the initial Green Mountain Care benefit package pursuant to 18 V.S.A. § 9375.

(4) Enactment of the appropriations for the initial Green Mountain Care benefit package proposed by the Green Mountain Care Board pursuant to 18 V.S.A. § 9375.

(5) A determination by the Green Mountain Care Board, as the result of a detailed and transparent analysis, that each of the following conditions will be met:

(A) Each Vermont resident covered by Green Mountain Care will receive benefits with an actuarial value of 80 percent or greater.

(B) When implemented, Green Mountain Care will not have a negative aggregate impact on Vermont's economy. This determination shall include an analysis of the impact of implementation on economic growth.

(C) The financing for Green Mountain Care is sustainable. In this analysis, the Board shall consider at least a five-year revenue forecast using the consensus process established in 32 V.S.A. § 305a, projections of federal and other funds available to support Green Mountain Care, and estimated expenses for Green Mountain Care for an equivalent time period.

(D) Administrative expenses in Vermont's health care system for which data are available will be reduced below 2011 levels, adjusted for inflation and other factors as necessary to reflect the present value of 2011 dollars at the time of the analysis.

(E) Cost-containment efforts will result in a reduction in the rate of growth in Vermont's per-capita health care spending without reducing access to necessary care or resulting in excessive wait times for services.

(F) Health care professionals will be reimbursed at levels sufficient to allow Vermont to recruit and retain high-quality health care professionals.

(b) As soon as allowed under federal law, the Secretary of Administration shall seek a waiver to allow the State to suspend operation of the Vermont Health Benefit Exchange and to enable Vermont to receive the appropriate federal fund contribution in lieu of the federal premium tax credits, cost-sharing

subsidies, and small business tax credits provided in the Affordable Care Act. The Secretary may seek a waiver from other provisions of the Affordable Care Act as necessary to ensure the operation of Green Mountain Care.

(c) The Green Mountain Care Board's analysis prepared pursuant to subdivision (a)(5) of this section shall be made available to the General Assembly and the public and shall include:

(1) a complete fiscal projection of revenues and expenses, as described in subdivision (a)(5) of this section, including reserves, if recommended, and other costs in addition to the cost of services, over at least a five-year period for a public-private universal health care system providing benefits with an actuarial value of 80 percent or greater;

(2) the financing plans provided to the General Assembly in January 2013 pursuant to Sec. 9 of No. 48 of the Acts of 2011;

(3) an analysis of how implementing Green Mountain Care will further the principles of health care reform expressed in 18 V.S.A. § 9371 beyond the reforms established through the Blueprint for Health; and

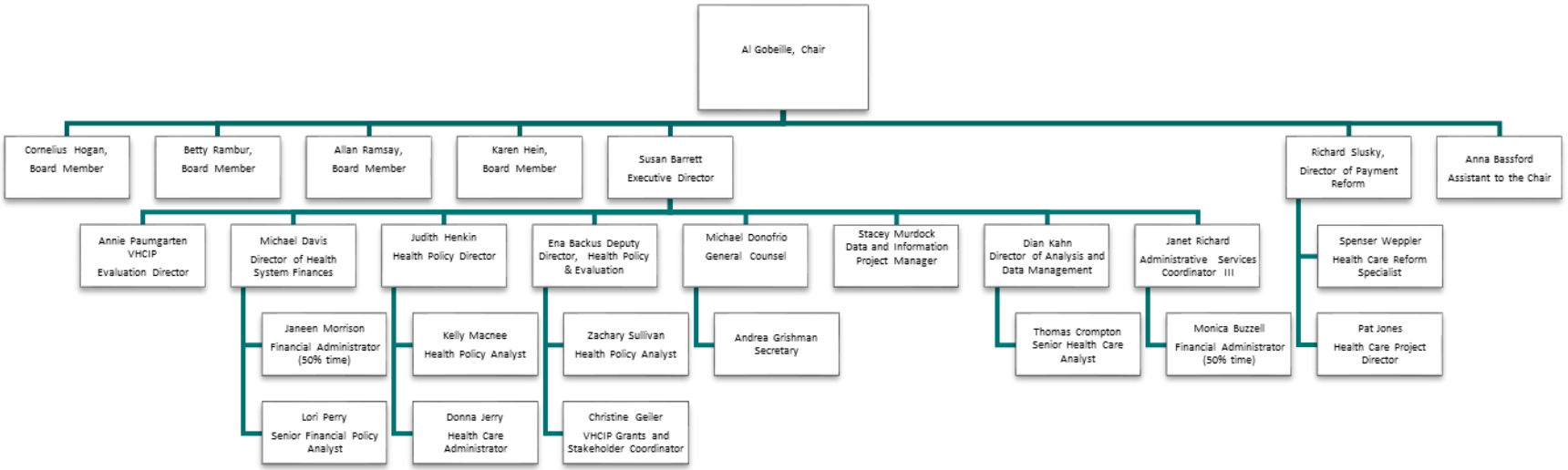
(4) a comparison of best practices for reducing health care costs in self-funded plans, if available.

Appendix E: GMCB Budget & Staffing

GMCB FY 14 and Proposed FY 15 Budgets

Department	**Positions**	**FY14 Estimated Expenditures**	**FY15 Proposed Expenditures**
Green Mountain Care Board	28	7,534,717	8,079,820
General Fund		1,110,364	535,193
Special Fund(Billback)		845,394	1,362,045
Global Commitment		2,360,462	2,534,955
Interdepartmental Transfer (from DFR and DVHA MOUs)		3,053,463	3,482,593
Special (RWJ)		165,034	165,034
Expenses by category			
Personal Services: Personnel Salary and Fringe		2,331,145	2,630,627
Personal Services: Third Party Contracts		4,915,671	4,602,333
Operating Expenses		287,901	846,860

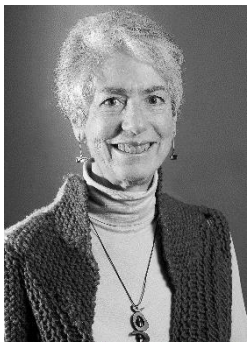
GMCB Organizational Chart
January, 2014



Appendix F: Board Biographies

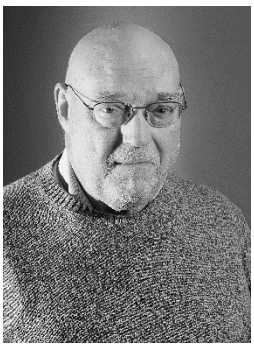
Alfred Gobeille, Chair, owns and operates Gobeille Hospitality, a Burlington-based restaurant and hospitality business that employs 230 people at Shanty on the Shore, Burlington Bay Market and Café, Breakwater Café and Grill, and Northern Lights Cruises.

Al serves on the Town of Shelburne Selectboard. He is a past board member of the Visiting Nurse Association of Chittenden and Grand Isle Counties, and served on the State of Vermont's Payment Reform Advisory Committee. Al is a graduate of Norwich University and has served as an officer in the United States Army. He lives in Shelburne.



Karen Hein, M.D., is Adjunct Professor of Family & Community Medicine at Dartmouth Medical School and immediate past president of the William T. Grant Foundation. Since 2003, Karen has served on boards that focus on health care reform, as well as on youth development, global health and the professionalization of humanitarian assistance in other countries, including RAND Health, Consumers Union, the Robert Wood Johnson Foundation Clinical Scholars Program, the International Rescue Committee, and ChildFund International.

Karen spent 25 years on the faculty of Columbia University and the Albert Einstein School of Medicine, where her focus was adolescent HIV and AIDS. During the Clinton health reform effort, Karen served as a Robert Wood Johnson Health Policy Fellow with the U.S. Senate Finance Committee. She then served as Executive Officer of the Institute of Medicine from 1995-98. Karen holds a medical degree from Columbia University and is a board certified pediatrician. She has owned a home in Jacksonville, Vermont for 40 years and has lived there full-time since 2004.

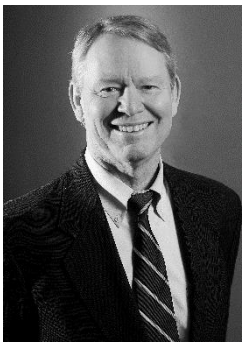


Cornelius Hogan served as Secretary of the Agency of Human Services (AHS) for the State of Vermont under both the Snelling and Dean administrations. Since his retirement from state service in 1999, Con has consulted internationally with governments on human services and health care management. He has co-authored several books on Vermont's health policy. Prior to serving as AHS Secretary, Con was for more than 10 years President of International Coins and Currency based in Montpelier.

Con served in leadership positions at the Vermont Department of Corrections and previously worked for the New Jersey Department of Corrections. Con holds a Master's of Governmental Administration from the Wharton School of Business at the University of Pennsylvania, and an Honorary Doctorate of Laws from the University of Vermont. He lives in Plainfield.

Betty Rambur, Ph.D., R.N. is Professor of Nursing and Health Policy at the University of Vermont (UVM). From 2000-2009 she served as an academic dean at UVM, where she led the merger of the School of Nursing and School of Health Sciences to establish the College of Nursing and Health Sciences.

From 1991-1995 Betty led the statewide health financing reform effort in North Dakota. She maintains an active research program focused on health services, quality, workforce, and ethics. She has led or participated in research, education, and public service grants exceeding $2 million and is the author of approximately 40 published articles and numerous invited presentations on her research, health care economics and policy, and leadership development. In 2007, her research was honored by Sigma Theta Tau International. In 2013, Betty received the UVM Graduate Student Senate Excellence in Teaching Award and the Sloan Consortium Excellence in Online Teaching and Learning Award. Her teaching expertise includes the organization, finance and policy of health care and evidence-based practice. Betty is currently writing a textbook designed to explain health care finance, economics, and policy in an easy-to-understand, reader-friendly manner. A registered nurse, Betty received her Ph.D. in nursing from Rush University in Chicago, IL. She lives in South Burlington.



Allan Ramsay, M.D. is a Colchester-based primary care physician who has practiced in Vermont for 30 years. Allan's signature work is in the area of palliative care, where he has been a leader in developing models for assuring that patients' wishes are followed at the end of their life. He is past Medical Director of Fletcher Allen Health Care's Palliative Care Service and the founder of the Rural Palliative Care Network.

In his long career in academic medicine, Allan served as Residency Director and Vice Chair in the Department of Family Medicine at UVM, where he is now Professor Emeritus. Allan is a past member of the board of the Visiting Nurse Association of Chittenden and Grand Isle Counties and the Board of the Community Health Center of Burlington. Prior to moving to Vermont, Allan served in the National Health Service Corps in rural Colorado. He was also President of an HMO Professional Service Corporation in the San Luis Valley of southern Colorado. Allan holds a medical degree from Emory University and is board certified in internal medicine, geriatrics, hospice and palliative medicine. He lives in Essex Junction.

Susan J. Barrett, J.D., Executive Director, an attorney, was formerly Director of Public Policy in Vermont for the Bi-State Primary Care Association. She joined Bi-State in 2011 after nearly 20 years in the pharmaceutical industry with Novartis, Merck, and Wyeth. Susan's health care experience also includes pro bono legal work and an internship with Health Law Advocates (HLA), a non-profit public interest law firm in Massachusetts. She is a graduate of New England Law Boston and Regis College. She lives in Norwich.

Green Mountain Care Board

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